Narrativas culturales en movimiento: una perspectiva sociocultural sobre la rehabilitación deportiva y la fisioterapia

Cultural narratives in movement: a sociocultural perspective on sports rehabilitation and physical therapy

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Abstract

Introduction: Sports rehabilitation and physical therapy are often framed through biomedical lenses, focusing on mechanical recovery and clinical metrics. Recovery is also a deeply cultural and social process shaped by narratives of identity, power, and belonging. Individuals undergoing rehabilitation navigate not only physical limitations but also sociocultural expectations related to gender, language, and bodily norms. Understanding these experiences requires a framework that captures the intersection of movement, meaning, and culture.

Methods: A qualitative narrative inquiry approach was adopted to explore the lived experiences of 18 participants, including athletes, chronic patients, and physical therapists, in two culturally diverse Indian urban settings. Data were gathered through semi-structured interviews, reflective journals, and observations in clinical rehabilitation spaces. Thematic analysis was conducted using NVivo, guided by sociocultural and embodiment theory.

Results: Three key themes emerged: Embodied identity reconstruction, reflecting participants' renegotiation of bodily self after injury; Cultural scripts and expectations, revealing the impact of social norms, gender roles, and linguistic barriers on recovery engagement; and Power and autonomy in therapy, highlighting variations in patient agency based on therapeutic dynamics. Participants who received culturally responsive care reported greater emotional resilience and engagement, whereas those facing cultural or communication disconnects expressed feelings of disempowerment and disengagement.

Conclusions: The findings underscore the need for culturally responsive and narrative-sensitive rehabilitation practices. Recognizing recovery as a socially constructed, identity-redefining process shaped by cultural expectations and therapeutic relationships can enhance care quality. Future approaches should prioritize patient agency, inclusive communication, and culturally grounded strategies to foster more equitable and effective healing environments.

Keywords

Cultural narratives; identity reconstruction; narrative inquiry; physical therapy; sociocultural rehabilitation.

Resumen

Introducción: La rehabilitación deportiva y la fisioterapia a menudo se enmarcan a través de lentes biomédicos, centrándose en la recuperación mecánica y las métricas clínicas. Sin embargo, la recuperación también es un proceso profundamente cultural y social moldeado por narrativas de identidad, poder y pertenencia. Las personas en rehabilitación navegan no solo por las limitaciones físicas, sino también por las expectativas socioculturales relacionadas con el género, el lenguaje y las normas corporales. Comprender estas experiencias requiere un marco que capture la intersección del movimiento, el significado y la cultura.

Métodos: Se adoptó un enfoque de indagación narrativa cualitativa para explorar las experiencias vividas de 18 participantes, incluidos atletas, pacientes crónicos y fisioterapeutas, en dos entornos urbanos indios culturalmente diversos. Los datos fueron recolectados a través de entrevistas semiestructuradas, revistas reflexivas y observaciones en espacios clínicos de rehabilitación. El análisis temático se llevó a cabo utilizando NVivo, guiado por la teoría sociocultural y de la encarnación.

Resultados: Surgieron tres temas clave: la reconstrucción de la identidad encarnada, que refleja la renegociación del yo corporal de los participantes después de una lesión; Guiones y expectativas culturales, que revelan el impacto de las normas sociales, los roles de género y las barreras lingüísticas en la participación en la recuperación; y Poder y autonomía en la terapia, destacando las variaciones en la agencia del paciente en función de la dinámica terapéutica. Los participantes que recibieron atención culturalmente receptiva informaron una mayor resiliencia emocional y compromiso, mientras que aquellos que enfrentaron desconexiones culturales o de comunicación expresaron sentimientos de desempoderamiento y falta de compromiso.

Conclusiones: Los hallazgos subrayan la necesidad de prácticas de rehabilitación culturalmente sensibles y sensibles a la narrativa. Reconocer la recuperación como un proceso de redefinición de la identidad socialmente construido, moldeado por las expectativas culturales y las relaciones terapéuticas, puede mejorar la calidad de la atención. Los enfoques futuros deben
priorizar la agencia del paciente, la comunicación inclusiva y las estrategias culturalmente fundamentadas para fomentar entornos de curación más equitativos y efectivos.

Palabras clave

Narrativas culturales; reconstrucción de la identidad; indagación narrativa; fisioterapia; rehabilitación sociocultural.

Introduction

The disciplines of sports rehabilitation and physical therapy have historically been embedded within biomedical paradigms, focusing on anatomical correction, mechanical function, and physiological optimization. These frameworks, while essential, tend to reduce the body to a neutral and decontextualized object of clinical intervention. Contemporary scholarship increasingly recognizes the limitations of this reductionist view, advocating instead for perspectives that incorporate the cultural, symbolic, and experiential dimensions of health and recovery (Markula-Denison & Pringle, 2007; Andrews, 2008). Sport and rehabilitation are not merely physical practices; they are deeply enmeshed within sociocultural systems that shape how bodies are disciplined, evaluated, and restored. For example, Bourdieu (1978) examined how social class structures access to and participation in sport, while Messner (1995) illuminated how sport reinforces hegemonic masculinity. These dynamics do not vanish in the context of injury or rehabilitation; rather, they take on renewed significance, influencing how athletes interpret injury, cope with limitations, and navigate their return to performance (Sparkes, 1998).

The context of rehabilitation is a social construction of space itself, and it is bound by the cultural scripts and power relations, as well as institutional norms. Foucault (1977) emphasized the fact that bodies are made docile by surveillance and discipline, which is easily seen in clinical and rehabilitative environments. Such spaces not only address physical impairments but also replicate ideals of normative ideas on body functioning, productivity, and independence (Garland-Thomson, 2005; Thomas, 2017). When patients do not fit these ideals, because of chronic illness, disability, or sociocultural difference, they are likely to be marginalized by the systems that believe in standardization over person-centered care (Kleinman, 2020; Hammell, 2006). The embodiment theory and phenomenology have also been crucial in transforming our perception of rehabilitation. Instead of regarding the body as an object of care, they focus on the experience of the person, on the embodied experience of the senses, emotions, and the meaning of healing (Csordas, 1994; Young, 2005). Rehabilitation turns out to no longer be an exclusively technical work of restoration but an intensely individual one of self-reconstruction, identity bargaining, and social recovery (Frank, 2013).

Although there is more and more clamor to adopt a more holistic and socially conscious practice, the mainstream rehabilitation practice still tends to be based on clinical objectivity and the efficiency of procedures. The paradigm overlooks cultural accounts and power relations that play an important role in the experience and the meaning that people ascribe to injury and recovery (Gibson & Teachman, 2012; Wade, 2005). As a result, patients might be forced to work in a foreign healthcare environment, where biomedical results are valued more than emotional or cultural appeal. Such limitations are especially evident when examining disparities in access to and quality of rehabilitation services. Social determinants of health—such as race, income, geography, and educational background—consistently influence who receives care, how it is delivered, and with what outcomes (Braaten et al., 2021; Lane et al., 2023). Even when access is available, cultural misalignment between practitioners and patients can lead to miscommunication, non-compliance, and dissatisfaction (Kirmayer, 2004; Kaplan, Tenam-Zemach, & Reeves, 2024). Popular narratives about recovery often valorize the "overcoming" of disability or the "triumph" of the human spirit, subtly reinforcing ableist ideals while obscuring the structural barriers that shape health experiences (Howe, 2011; Garland-Thomson, 2005). These cultural scripts can impose unrealistic expectations on individuals undergoing rehabilitation and can stigmatize those who do not return to pre-injury norms of physical function or independence.

The study is situated within the growing body of scholarship that integrates sociocultural, anthropological, and critical theory perspectives into the analysis of sports rehabilitation and physical therapy. It draws upon diverse theoretical frameworks—including embodiment, discourse analysis, cultural studies, and medical sociology—to explore the multilayered experience of rehabilitation. Several boundaries frame this inquiry. Firstly, the study emphasizes theoretical and qualitative insights rather than quantitative or clinical outcome measures. While such clinical data is valuable, the research prioritizes interpretive depth and cultural critique (Geertz, 1973; Giddens, 1984). Secondly, the geographic and cultural focus is primarily on Western healthcare contexts, where biomedical models are most dominant and where the tension between standardization and personalization is most pronounced (Hargreaves & Vertinsky, 2007; Brown & Leledaki, 2010). The scope also excludes in-depth

analysis of pediatric or geriatric rehabilitation, focusing instead on adult populations within athletic, therapeutic, and rehabilitative spaces. While gender, race, class, and ability are examined as key social categories, the study does not seek to provide exhaustive accounts of each but rather to illustrate their intersectional impact on rehabilitation narratives (Hall, 1997; Thomas, 2017).

By adopting a sociocultural lens, the research contributes to a broader and more humanistic understanding of rehabilitation. It challenges prevailing clinical orthodoxies by emphasizing the lived experiences, cultural contexts, and narrative constructions of those undergoing physical therapy. In doing so, it not only enriches academic discourse but also holds potential practical value for health practitioners, educators, and policymakers. For clinicians, the study underscores the importance of cultural humility and reflective practice—traits that are increasingly recognized as essential to effective care (Kaplan et al., 2024; Kirmayer, 2004). Understanding the symbolic and emotional dimensions of recovery can improve therapeutic rapport, enhance patient engagement, and foster more inclusive care environments.

For educators and researchers, this work strengthens the growing call to embed critical theory and cultural competence into physical therapy curricula. Such an approach prepares future practitioners to navigate diverse sociocultural landscapes and to interrogate their own biases and assumptions (Darnell, 2012; Andrews, 2008). Finally, for policymakers, the study provides a framework to recognize and address disparities in rehabilitation access and outcomes. It advocates for more equitable distribution of resources, culturally attuned service models, and policy frameworks that affirm bodily diversity and narrative pluralism (Braaten et al., 2021; Lane et al., 2023).

Research objectives

The study aims to explore the sociocultural dimensions of sports rehabilitation and physical therapy through a multidisciplinary lens. Its core objectives are as follows:

- To examine how cultural narratives and symbolic meanings shape the experience of injury, recovery, and physical rehabilitation
- To investigate the role of power, identity, and representation within therapeutic and rehabilitative contexts
- To identify sociocultural and systemic factors influencing disparities in access to and outcomes of physical therapy services

Method

A qualitative approach using narrative inquiry guided the research to investigate how cultural narratives shape individuals' experiences of sports rehabilitation and physical therapy. The methodological framework aligned with the research aim of exploring how people's identities, perceptions of their bodies, and healing journeys are shaped by cultural meanings and social structures. Narrative inquiry, understood both as a method and a phenomenon, provided a powerful lens to access and interpret the stories individuals tell about their recovery processes. Rooted in a sociocultural perspective, the study emphasized how rehabilitation experiences are embedded within larger systems of cultural representation, power, and embodiment. This sociocultural lens guided all stages of the research, including the choice of participants, data interpretation, and all other processes of the study, such that context, identity, and community practices were at the forefront of learning about rehabilitation as a cultural process. The study explored therapeutic and athletic recovery environments to explore the role of cultural scripts on individuals in the rehabilitation process in terms of agency, self-worth, and body identity.

Participants

The study included 18 participants who had dissimilar connections to sports rehabilitation and physical therapy, and these participants were chosen in two metropolitan cities of India that had dissimilar cultural topographies. The sample consisted of 10 rehabilitation participants who had recovered after athletic injuries, 5 persons with chronic musculoskeletal problems, and 3 physical therapists with a

license to work with culturally diverse clients. They were 22-48-year-old individuals with diverse gender and socioeconomic status. Most of them belonged to the local linguistic group, like Hindi, Marathi, Tamil, and Punjabi, and they had participated in the rehabilitative programs that were being conducted in the different institutions, both governmental and privately owned. The criteria of selection were based on the persons who had at least 3 months of rehabilitation experience and were able to tell personal stories of recovery, identity negotiation, or cultural tensions in their process of therapy. All the participants were informed and gave their consent to participate in the research, and the research protocol was reviewed and approved by the Institutional Ethics Committee of the university. To be ethically rigorous, subjects were made aware of the confidentiality and voluntary nature of the study as well as the option to withdraw at any time.

Procedure

The data was collected during the four months and consisted of three major methods: narrative interviews, reflective recovery journals, and field-based observations in rehabilitation places. All the participants were involved in two semi-structured interviews, lasting 60-75 minutes, which were carried out in their language of choice or a bilingual form. The interviews were conducted to get rich accounts of their rehabilitation experiences, their emotional reactions, bodily sensations, and cultural explanations of injury and recovery. Consenting recording and verbatim transcription of all interviews were done.

Participants who had undergone rehabilitation were asked to maintain reflective journals over six weeks. These journals captured weekly reflections on their physical progress, emotional shifts, therapeutic encounters, and evolving bodily identity. This narrative material provided longitudinal insights into how meaning was constructed across the recovery trajectory. For contextual triangulation, field observations were conducted in four rehabilitation clinics and two sports recovery centers. A total of 12 sessions were observed, with the researcher attending different therapy modalities such as manual therapy, movement-based sessions, and patient consultations. Observational field notes focused on therapist-client interactions, cultural communication styles, spatial arrangements, and performative bodily expressions that revealed embedded sociocultural dynamics.

Instrument

The core instrument used for data collection was a narrative interview protocol structured to prompt reflective storytelling. The guide included open-ended questions designed to elicit personal narratives and emotional depth. Sample questions included:

- “Can you recall a moment in your therapy that changed how you viewed your body?”
- “How did your cultural background shape your expectations or emotions during recovery?”

These questions encouraged participants to draw on memory, metaphor, and emotion to explore their healing narratives.

Apart from the interview instructions, a reflective prompt framework was developed for the journals. This included weekly cues aimed at guiding participants' written reflections. Sample prompts included:

- “Describe a moment this week when you felt empowered or frustrated in therapy.”
- “What cultural messages about strength or recovery have you noticed influencing your thinking?”

These prompts supported depth and consistency in journal entries, offering longitudinal insight into each participant’s evolving rehabilitation experience.

Data analysis

All narrative data—including interview transcripts and journal entries—were analyzed thematically using Braun and Clarke’s six-phase model of thematic analysis. NVivo software (version 14) facilitated data organization, initial coding, and thematic clustering. Open coding generated an initial set of narrative units, which were then categorized into broader thematic clusters.

Three main analytical dimensions were used to guide theme development: embodied identity (how individuals perceived and redefined their bodies), cultural scripts (prevailing cultural expectations

around pain, recovery, and resilience), and therapeutic power dynamics (how authority, expertise, and compliance were negotiated in therapy). Themes were cross-validated through participant triangulation and interpretive memoing and were interpreted within a sociocultural theoretical framework to uncover how recovery narratives intersect with cultural ideologies, institutional norms, and individual identity construction.

Results

Thematic analysis of the data from 18 participants revealed three primary themes that characterized the sociocultural dimensions of rehabilitation: Embodied Identity Reconstruction, Cultural Scripts and Expectations, and Power and Autonomy in Therapeutic Relationships. These themes were shaped by participants' gender, sociocultural background, and roles (athlete, patient, or therapist). Numerical tables were used to represent thematic frequencies, distributions, and intersections across participant experiences.

Embodied Identity Reconstruction

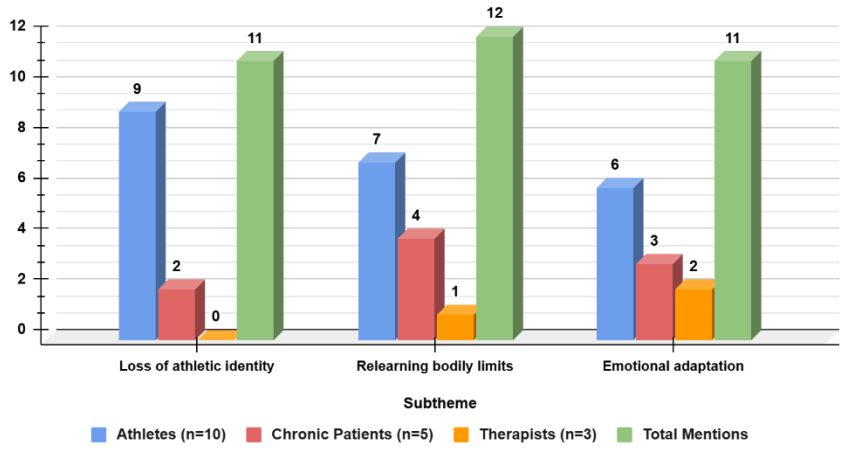
Study participants always described their rehabilitation experiences as a highly transformational, embodied identity-rebuilding process. To most people, especially athletes, the early phases of recovery were characterized by a strong feeling of identity disturbance where injury interfered with their self-identity based on strength, performance, and physical autonomy. This disturbance usually resulted in emotional turmoil and loss of direction. As the treatment went on, the participants reported that they had gained a new sense of their bodies, not only in the sense of physical tools but also as dynamic, adaptive, and resilient beings. As a result of the sustained rehabilitation process, people began to re-conceptualize their physical constraints as the sources of growth and awareness. These observations are also supported by the frequency of the themes provided in Table 1, which indicates the popularity of identity loss, the development of the sense of a body, and emotional strength in the stories of participants.

Table 1. Frequency of Identity Reconstruction Themes by Participant Group

Subtheme	Athletes (n=10)	Chronic Patients (N=5)	Therapists (n=3)	Total Mentions
Loss of athletic identity	9	2	0	11
Relearning bodily limits	7	4	1	12
Emotional adaptation	6	3	2	11

"I didn't just lose my strength—I lost who I was on the field." – P7
"The hardest part was letting go of the idea that I could bounce back like nothing happened." – P2

Figure 1. Subtheme Mentions by Participant Group



Cultural Scripts and Expectations

The results indicated that cultural scripts and expectations played an important role in how the participants went about and experienced rehabilitation. Strong cultural discourses, especially those concerning gender and family roles, influenced the expression and participation in therapy. The male

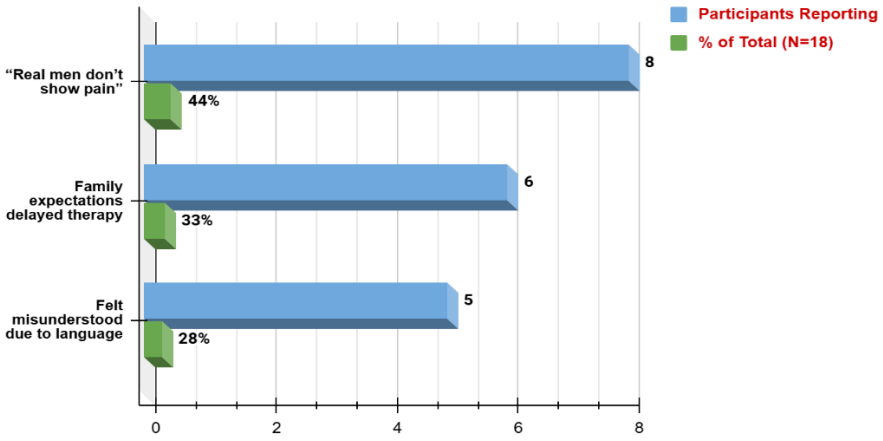
subjects usually felt the need to hold down their vulnerability, as powerful ideals about masculinity meant that they were tough, whereas other subjects stated that they had to take care of their families more than their own recovery needs. Some of them had language-related issues in clinical communication, which caused alienation and misunderstanding. These sociocultural pressures usually interfered with effective involvement in therapy, as evidenced by the frequency and distribution of experiences as outlined in Table 2.

Table 2. Cultural Narratives Reported by Participants

Cultural Narrative	Participants Reporting	% of Total (N=18)
"Real men don't show pain."	8 (male-identifying)	44%
Family expectations of delayed therapy	6	33%
Felt misunderstood due to language	5	28%

"In my family, stopping to recover means you're weak. I was expected to carry on." – P9.
"The therapist used English terms I didn't understand, but I was too embarrassed to ask." – P14.

Figure 2. Cultural Narratives Impacting Therapy Engagement



Power and Autonomy in Therapeutic Relationships

The feeling of power and autonomy among the participants in therapeutic relationships was quite different according to the type of care given. Patients who had a cooperative and understanding experience with therapists felt more trust, motivation, and participated more in their recovery. These participants were made to feel like they are not only patients but individuals with their own cultural and emotional requirements. Conversely, other people referred to hierarchical and compliance-based systems where decisions were dictated but not discussed, which caused a sense of objectification and loss of power. The level of satisfaction and patient agency was highly correlated with the sensitivity and communication of the therapist, as shown in the participant distribution as shown in Table 3.

Table 3. Participant Distribution Along Therapeutic Engagement Spectrum

Engagement Category	Description	No. of Participants	% (N=18)
Empowered	Reported collaborative, inclusive care	7	39%
Mixed/Partial Autonomy	Reported some collaboration, but limited say	6	33%
Disempowered	Felt excluded from decision-making	5	28%

"My therapist asked how I wanted to proceed. That was the first time I felt like a partner, not a patient." – P11.
"It felt like they were treating the injury, not the person behind it." – P3.

Cross-Cutting Patterns

The analysis showed a number of cross-cutting patterns that help visualize the multifaceted interrelationship between the cultural background, identity, and power relations in the process of rehabilitation. The intersection of these dimensions demonstrated that the cultural expectations, especially masculinity-related ones, tended to add to the disempowerment, as the male participants reported being unwilling to show their vulnerability and ask for help. Conversely, individuals who encountered culturally sensitive and linguistically accessible therapy environments reported greater

empowerment and a more positive process of identity reconstruction. The intersection of these themes is illustrated in Table 4, which maps individual participant experiences across identity disruption, cultural script conflicts, and perceived levels of agency within therapeutic relationships.

Table 4. Summary Matrix: Participant Experience by Theme

Participant	Identity Disruption	Cultural Scripts Conflict	Empowerment in Therapy
P5	High	Gender norms	Low
P11	Moderate	Supportive family	High
P14	High	Language barriers	Low
P2	Low	Cultural alignment	High

These cross-theme intersections demonstrate how cultural alignment—particularly in language and therapist sensitivity—enhanced participants' sense of agency, self-worth, and bodily confidence. Conversely, cultural dissonance and gender norms contributed to emotional silencing, therapy avoidance, or disengagement.

"When culture is ignored, therapy becomes mechanical." – P17 (Therapist)

Discussion

The findings of the study demonstrate that sports rehabilitation and physical therapy are experienced not only as physiological processes but also as culturally and socially mediated journeys. Participants' narratives revealed that rehabilitation often disrupted previously held bodily identities, especially among athletes, where performance, strength, and self-worth were tightly intertwined. The theme of embodied identity reconstruction highlighted the existential dissonance that arises when an athletic body, once associated with agency and productivity, becomes dependent and limited (Frank, 2013). Yet, for many, this disruption opened pathways to develop a new sense of bodily awareness and emotional resilience, underscoring the body not only as an object of recovery but also as a site of meaning-making (Csordas, 1994; Young, 2005).

The second major theme, cultural scripts and expectations, emphasized the profound influence of sociocultural norms on the rehabilitation process. Participants reported internalizing gender norms, familial expectations, and cultural beliefs that either supported or hindered their engagement with therapy. Male participants often expressed a reluctance to show vulnerability or acknowledge pain, aligning with dominant masculine ideals in sport culture (Messner, 1995). Others spoke of familial obligations or cultural stigmas around rest and dependency, suggesting that these narratives can delay or complicate recovery (Bourdieu, 1978; Thomas, 2017). Language also emerged as a critical factor; participants from linguistically marginalized communities felt alienated in clinical settings where dominant medical discourse was inaccessible or culturally incongruent (Garland-Thomson, 2005; Kaplan, Tenam-Zemach, & Reeves, 2024).

The third theme, power and autonomy in therapeutic relationships, illustrated how structural and interpersonal dynamics shaped participants' sense of agency. Those who experienced collaborative care described feeling empowered and validated, while others recounted being sidelined in decision-making, reinforcing a hierarchy between clinician and patient (Foucault, 1977; Hammell, 2006). The quality of these interactions played a pivotal role in how participants engaged with their bodies, treatment plans, and future goals. Cross-cutting patterns among themes further affirmed that cultural alignment and responsive care facilitated more positive identity reconstruction and therapeutic engagement. Conversely, misalignment—whether linguistic, cultural, or ideological—often led to emotional disengagement, frustration, or withdrawal from care.

The results resonate strongly with previous sociocultural and phenomenological research on embodiment, health, and rehabilitation. Csordas (1994) and Frank (2013) have emphasized that the body in medical settings should not be reduced to a biomechanical entity but understood as a lived and subjective experience. This view was echoed by participants who expressed emotional shifts in how they perceived their bodies during therapy, not just as sites of pain or malfunction but as repositories of history, emotion, and resilience. The influence of cultural narratives, particularly around gender, discipline, and ability, aligns with foundational work by Bourdieu (1978) and Hall (1997), who argued

that social institutions—including sport and healthcare—are arenas where dominant ideologies are reinforced. The expectation of masculine stoicism or the cultural valorization of "quick recovery" echoes what Sparkes (1998) referred to as the "Achilles' heel" of athletic identity—the psychological toll of failing to meet cultural ideals of strength and autonomy.

In terms of practitioner-patient dynamics, the data reinforced Foucault's (1977) concept of medical power and surveillance, wherein clinical authority often silences patient subjectivity. Participants who experienced collaborative relationships found more room for agency and narrative expression, aligning with more contemporary calls for culturally competent and patient-centered care (Hammell, 2006; Kaplan et al., 2024). These findings also add to the work of Kirmayer (2004) about metaphor and meaning in healing, which shows how people develop therapeutic meaning using cultural and symbolic constructs as well as clinical outcomes. Notably, the results reflect on the issues of disability and critical health studies regarding the normative assumptions within the therapeutic models (Garland-Thomson, 2005; Thomas, 2017). In their refusal to choose between the categories of a disabled person and a recovered one, the participants emphasized the multiplicity and fluidity of the healing process as these aspects are described by Young (2005) and Frank (2013) regarding the difference of body and the ethics of care.

These results are significant both to practice and healthcare policy. They recommend that a cultural humility approach and narrative competence be included in the physical rehabilitation programs. Instead of strictly following standardized regimes, therapists should be able to listen to patients, their stories, cultures, and emotional terrain, particularly in cases when working with persons of different sociocultural backgrounds (Kaplan et al., 2024; Kirmayer, 2004). The potential of language and communication should be re-discussed. The clinics that target multilingual communities are advised to make an investment in linguistically inclusive approaches, including the use of interpreters, cultural adaptation of communication strategies, or multilingual learning resources, to minimize the barriers and increase equity (Lane et al., 2023). The findings indicate the necessity to reconsider assessment measures. The traditional measures of success in rehabilitation tend to emphasize speed and functionality rather than subjective well-being and conformity with culture. It may be more productive to use more patient-centered assessments that include identity reconstruction and patient agency (Wade, 2005; Darnell, 2012).

Lastly, the sociocultural theory, embodiment, and narrative analysis should be highlighted as the essential elements of clinical training that a therapist should learn. In this way, future professionals will be more ready to provide person-centered care that does not fit the lived experience of patients into reductive medical standards (Andrews, 2008; Gibson & Teachman, 2012).

Although the study provides the reader with a rich narrative, there are a few limitations that have to be considered. The size of the sample is suitable for qualitative research, but it restricts generalizability. The sample was chosen in two urban areas in India, and their experiences might not be specific to people living in the countryside or in other cultures. Despite efforts to include diverse voices, the sample included only three therapists. Including more practitioners may have offered broader perspectives on institutional constraints and therapist-patient dynamics. While the study triangulated interviews, journals, and observations, it relied on self-reported data, which may be influenced by recall bias or social desirability. Observational data, while valuable, were limited to specific sessions and could not capture longitudinal therapeutic interactions. Lastly, the absence of pediatric and geriatric perspectives means that generational factors influencing cultural narratives and embodiment were not explored in depth.

Future research should consider expanding the demographic and geographic scope of participants to include rural populations, non-athlete clients, and non-binary or transgender individuals—groups whose narratives are often marginalized in rehabilitation literature. Longitudinal studies could better track how identity, cultural narratives, and agency evolve throughout the full arc of rehabilitation. There is a need to examine institutional practices and systemic barriers in greater depth, especially regarding how funding models, staffing ratios, and policy structures affect the delivery of culturally responsive care (Braaten et al., 2021). Collaborative research involving both practitioners and clients could illuminate power asymmetries more comprehensively and help co-create equitable care strategies.

Integrating digital ethnography and autoethnographic approaches may provide deeper insight into how individuals use social media, online communities, and technology to reconstruct their identities and mobilize cultural narratives around recovery and resilience (Brown & Leledaki, 2010; Allen-Collinson & Hockey, 2011).

Conclusions

Rehabilitation, as revealed through participants' narratives, emerges as a deeply personal and culturally embedded process. Identity disruption, especially among athletes, highlighted the emotional toll of injury and the challenges of redefining the self about a changed body. Cultural scripts—such as masculinity norms, family obligations, and language expectations—were shown to shape participants' engagement with therapy. The nature of therapeutic relationships further influenced recovery, where empowering, empathetic care fostered greater agency, while hierarchical models often led to emotional detachment and withdrawal. These findings have significant implications for physical therapy and sports rehabilitation practices. Healing is not solely biomechanical; it is also symbolic, emotional, and contextual. Recognizing the cultural frameworks through which individuals interpret pain, progress, and resilience allows for more human-centered care. Therapists who actively engage with patients' stories, identities, and cultural backgrounds can enhance not only compliance but also the overall efficacy and meaning of rehabilitation. Several recommendations emerge from the findings. Clinical settings must prioritize cultural responsiveness through language access, shared decision-making, and training programs that embed sociocultural awareness into therapeutic education. Rehabilitation protocols should be flexible enough to accommodate diverse cultural expectations and emotional expressions of recovery. For future research, expanding participant demographics across rural, gender-diverse, and older populations will offer a more inclusive understanding of rehabilitation experiences. Longitudinal studies could explore how identity, empowerment, and therapist-patient dynamics evolve. Investigating institutional constraints and systemic disparities will provide deeper insight into the structural forces that shape rehabilitation access and quality. Viewing rehabilitation as a culturally narrated and socially negotiated journey reframes recovery as more than clinical achievement—it becomes a form of re-embodiment, resilience, and identity restoration.

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