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Research Article

Psychosocial Adaptation and Prosthesis Acceptance Among Male and Female Lower-limb Amputees in Selected Centres in Nigeria

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Abstract

Lower-limb amputation is associated with substantial physical, psychological, and social challenges that may affect rehabilitation outcomes and prosthesis utilization. In Nigeria, limited rehabilitation services, financial barriers, and sociocultural factors may further influence psychosocial adaptation and prosthesis acceptance among individuals with limb loss. This study examined psychosocial adaptation and prosthesis acceptance among male and female lower-limb amputees in selected rehabilitation centres in Nigeria and determined the influence of social support on rehabilitation outcomes. A comparative cross-sectional survey was conducted among 503 lower-limb amputees recruited from selected rehabilitation centres using a multistage non-probability sampling technique. Data were collected using a structured questionnaire incorporating the Trinity Amputation and Prosthesis Experience Scales (TAPES) and the Multidimensional Scale of Perceived Social Support (MSPSS). Descriptive statistics, independent-samples t-tests, Pearson correlation analysis, and multiple regression analysis were performed using the Statistical Package for the Social Sciences (SPSS), version 26. Statistical significance was set at $p < 0.05$. Most participants demonstrated positive psychosocial adaptation and high prosthesis acceptance. Daily prosthesis use was reported by 77.3% of respondents, while functionality recorded the highest satisfaction score (4.02 ± 1.08). Male participants had significantly higher psychosocial adaptation and prosthesis satisfaction scores than females ($p < 0.05$). Social support was positively correlated with psychosocial adaptation ($r = 0.58$) and prosthesis acceptance ($r = 0.55$). Psychosocial adaptation and prosthesis acceptance among lower-limb amputees in Nigeria were positively associated and significantly influenced by social support and gender-related factors. Comprehensive rehabilitation programmes integrating psychological counselling, social support, and patient-centred prosthetic care are recommended to improve long-term functional and psychosocial outcomes.

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Keywords

Amputation, Prosthesis Acceptance, Psychosocial Adaptation, Rehabilitation, Social Support, Nigeria

1. Introduction

Lower-limb amputation is a life-changing condition that can affect physical functioning, psychological wellbeing, social participation, and quality of life. The global burden of limb loss is substantial [1, 2], while diabetes, trauma, infection, and other conditions contribute to amputation in different settings [3, 4]. In Nigeria and other sub-Saharan African settings, limited access to rehabilitation services, financial constraints, availability of prosthetic and orthotic services, and disability-related stigma may create additional barriers to rehabilitation and social inclusion [5-7, 10, 11]. Psychosocial adjustment after amputation is influenced by individual, psychological, and social factors [8, 9, 12-15]. Social support may buffer stress and facilitate resilience and rehabilitation [16]. Prosthetic rehabilitation is therefore not limited to restoring mobility; it also requires attention to user needs, participation, satisfaction, and long-term prosthesis use [17-20]. Evidence concerning gender-related differences in adaptation, coping, and prosthetic outcomes remains mixed, with literature suggesting differences in body image, coping, and functional priorities [21-24]. However, evidence from Nigeria remains limited, particularly regarding the relationship among psychosocial adaptation, prosthesis acceptance, perceived social support, and gender. This study therefore examined psychosocial adaptation and prosthesis acceptance among male and female lower-limb amputees in selected rehabilitation centres in Nigeria and assessed the relationship of these outcomes with perceived social support.

2. Materials and Methods

2.1. Study Design and Setting

This study adopted a comparative cross-sectional survey design to examine psychosocial adaptation and prosthesis acceptance among male and female lower-limb amputees in selected rehabilitation centers in Nigeria. The design was considered appropriate because it allows for the assessment of gender differences and the relationships among psychosocial adaptation, prosthesis acceptance, and perceived social support at a single point in time without manipulating the study variables.

The study was conducted at the Leprosy Mission Hospital Orthopaedic Workshop, Minna, Niger State, Fix and Fit Prosthetic and Orthotic Centre, Gwagwalada, Federal Capital Territory; and the University of Abuja Teaching Hospital, Gwagwalada, Federal Capital Territory. These centers were purposively selected because they provide specialized prosthetic and rehabilitation services, manage a large number of amputees, offer comprehensive prosthetic fitting and follow-up care.

2.2. Study Population and Eligibility Criteria

The study population comprised adult lower-limb amputees receiving rehabilitation care in the selected centers during the study period.

Inclusion criteria:

1) Aged 18 years or older
2) Had a unilateral or bilateral lower-limb amputation
3) Had used a prosthetic limb for at least six months
4) Were willing to provide informed consent

Exclusion criteria:

1) Had severe cognitive impairment
2) Had severe psychiatric conditions
3) Were not currently using a prosthesis

These criteria ensured that participants had adequate experience with prosthesis use and could provide reliable responses.

2.3. Sample Size Determination

Using Cochran's formula, the minimum sample size was 384. To allow for non-response and incomplete questionnaires, 550 questionnaires were distributed. Of these, 518 were returned (94.2%), and 503 were complete and included in the final analysis (503/550 = 91.5%).

The minimum sample size was calculated using Cochran's formula for a large population:

The formula is:

$$n = \frac{Z^2 \times p(1-p)}{d^2}$$

where n is the required sample size, Z is the standard normal deviate (1.96 for a 95% confidence level), p is the assumed proportion (0.50), and d is the margin of error (0.05). The calculated minimum sample size was 384. To allow for non-response and incomplete questionnaires, the target was increased to 550.

2.4. Sampling Technique

A multistage nonprobability sampling technique was employed for this study.

Stage One: Rehabilitation centers were purposively selected based on the availability of prosthetic rehabilitation services, high patient volume, accessibility, and willingness to participate in the study.

Stage Two: Eligible lower-limb amputees were identified using the study inclusion criteria.

Stage Three: Consecutive sampling was employed to recruit all eligible participants attending the selected facilities until the required sample size was achieved.

2.5. Data Collection and Study Instruments

Data were collected using a structured questionnaire divided into four sections:

Section A: Demographics

1) Age, gender, marital status, education, employment
2) Cause and level of amputation
3) Duration of prosthesis use

Section B: Psychosocial Adaptation

Measured using the Trinity Amputation and Prosthesis Experience Scales (TAPES).

Section C: Prosthesis Acceptance

Prosthesis acceptance was assessed using daily wearing time, satisfaction, comfort, and cosmetic perception.

1) Satisfaction levels (0-10 scale).
2) Comfort and cosmetic perception.

Section D: Social Support

Measured using the Multidimensional Scale of Perceived Social Support (MSPSS).

2.6. Reliability and Validity of Instruments

The study utilized standardized instruments, including the Trinity Amputation and Prosthesis Experience Scales (TAPES) and the Multidimensional Scale of Perceived Social Support (MSPSS), which have been previously validated in rehabilitation and psychosocial studies.

To ensure reliability of the instruments within the present study population, a pilot study was conducted among lower-limb amputees outside the selected study centres. Internal consistency reliability was assessed using Cronbach's alpha coefficient. The instruments demonstrated acceptable reliability coefficients above the recommended threshold of 0.70, indicating good internal consistency and suitability for the study.

Socio-Demographic Characteristics of Respondents

Face and content validity of the questionnaire were established through expert review by specialists in Prosthetics and Orthotics, rehabilitation, and research methodology. Necessary corrections and modifications were made based on their recommendations before final administration of the instrument.

2.7. Data Collection Procedure

Data were collected through face-to-face administration of the structured questionnaire.

1) Participants were informed about study objectives.
2) Informed consent was obtained.
3) Illiterate participants were assisted to ensure inclusivity.

Completed questionnaires were checked immediately to minimize missing data.

2.8. Data Analysis

Data were analyzed using the Statistical Package for the Social Sciences (SPSS), version 26.0. Descriptive statistics comprised frequencies, percentages, means, and standard deviations. Inferential analyses included independent-samples t-tests for gender comparisons, Pearson correlation analysis, and multiple linear regression. Statistical significance was set at $p < 0.05$.

3. Results

3.1. Participant Characteristics

A total of 550 questionnaires were distributed, of which 518 were returned, yielding a response rate of 94.2%. After data cleaning, 503 questionnaires were complete and included in the final analysis, resulting in an effective response rate of 91.5%.

3.2. Sociodemographic Characteristics

Among the 503 participants, 347 (69.0%) were male and 156 (31.0%) were female. The largest age group was 31-45 years (37.6%), followed by 46-60 years (28.0%), 18-30 years (20.3%), and over 60 years (14.1%). Most participants were married (57.1%), while 27.4% were single and 15.5% were widowed or divorced. Slightly more than half of the respondents (53.3%) were employed, whereas 46.7% were unemployed.

Table 1. *Socio-Demographic Characteristics (n = 503).*

Variable	Category	Frequency (n)	Percentage (%)
Gender	Male	347	69.0

Variable	Category	Frequency (n)	Percentage (%)
	Female	156	31.0
Age (years)	18–30	102	20.3
	31–45	189	37.6
	46–60	141	28.0
	>60	71	14.1
Marital Status	Single	138	27.4
	Married	287	57.1
	Widowed/Divorced	78	15.5
Employment Status	Employed	268	53.3
	Unemployed	235	46.7

3.3. Clinical Characteristics

Trauma was the leading cause of amputation, accounting for 54.9% of cases, followed by diabetes (23.5%), infection (13.3%), and other causes (8.3%). Below-knee amputation was more common than above-knee amputation (57.9% vs. 42.1%). Most participants had used their prostheses for more than one year, with 39.4% reporting 1-3 years of use and 39.9% reporting more than three years of use.

Clinical Characteristics of Respondents

Table 2. *Clinical Profile of Amputees (n = 503).*

Variable	Category	Frequency (n)	Percentage (%)
Cause of Amputation	Trauma	276	54.9
	Diabetes	118	23.5
	Infection	67	13.3
	Others	42	8.3
Level of Amputation	Above knee	212	42.1
	Below knee	291	57.9
Duration of Prosthesis Use	6 months–1 year	104	20.7
	1–3 years	198	39.4
	>3 years	201	39.9

3.4. Psychosocial Adaptation

Participants generally demonstrated positive psychosocial adaptation. The highest mean score was recorded for optimism about the future (4.07 ± 1.08), followed by self-confidence (3.99 ± 1.12) and body acceptance (3.99 ± 1.10). Perceived social acceptance had the lowest mean score (3.92 ± 1.15), indicating that some participants continued to experience challenges related to social integration despite generally favorable psychological adjustment.

Psychosocial Adaptation of Respondents

Table 3. Psychosocial Adaptation Scores (Likert Scale Analysis).

Item	SA (%)	A (%)	N (%)	D (%)	SD (%)	Mean ± SD
I feel confident about myself	45.2	30.1	10.5	8.2	6.0	3.99 ± 1.12
I have accepted my body condition	42.5	33.8	9.9	7.8	6.0	3.99 ± 1.10
I feel socially accepted	38.2	35.4	12.0	8.6	5.8	3.92 ± 1.15
I am optimistic about the future	47.1	29.8	11.2	7.0	4.9	4.07 ± 1.08

Key: SA = Strongly Agree; A = Agree; N = Neutral; D = Disagree; SD = Strongly Disagree.

3.5. Prosthesis Acceptance

Overall prosthesis acceptance was high. Daily prosthesis use was reported by 389 participants (77.3%), while 16.7% used their prostheses occasionally and 6.0% reported infrequent use. Nearly half of the respondents (45.9%) wore their prostheses for 5-10 hours each day, whereas 31.8% reported wearing them for more than 10 hours daily.

Prosthesis Acceptance

Table 4. Prosthesis Use Pattern (n = 503).

Variable	Category	Frequency (n)	Percentage (%)
Frequency of Use	Daily	389	77.3
	Occasionally	84	16.7
	Rarely	30	6.0
Daily Wearing Time	<5 hours	112	22.3
	5–10 hours	231	45.9
	>10 hours	160	31.8

Regarding prosthesis satisfaction, functionality received the highest mean score (4.02 ± 1.08), followed by overall satisfaction (3.92 ± 1.10) and comfort (3.85 ± 1.14). Cosmetic appearance had the lowest satisfaction score (3.60 ± 1.20), suggesting that aesthetic concerns remain an important consideration for prosthesis users.

Table 5. Prosthesis Satisfaction.

Item	Mean ± SD
Comfort	3.85 ± 1.14
Functionality	4.02 ± 1.08
Cosmetic appearance	3.60 ± 1.20
Overall satisfaction	3.92 ± 1.10

3.6. Perceived Social Support

Participants reported relatively high levels of perceived social support. Family support had the highest mean score (4.20 ± 0.95), followed by support from significant others (3.95 ± 1.02) and friends (3.88 ± 1.05). The overall perceived social support score was 4.01 ± 1.00, indicating that participants generally experienced strong social support during rehabilitation.

Social Support

Table 6. *Perceived Social Support (MSPSS Scores).*

Source of Support	Mean ± SD
Family	4.20 ± 0.95
Friends	3.88 ± 1.05
Significant others	3.95 ± 1.02
Overall score	4.01 ± 1.00

3.7. Gender Differences

Male participants demonstrated significantly higher psychosocial adaptation scores than female participants (4.02 ± 0.85 vs. 3.78 ± 0.91; $t = 2.45$, $p = 0.015$). Prosthesis satisfaction was also significantly higher among males (3.95 ± 0.88 vs. 3.70 ± 0.95; $t = 2.10$, $p = 0.036$). No statistically significant gender difference was observed in perceived social support ($p = 0.231$).

Gender Comparison (Inferential Statistics)

Table 7. *Gender Differences in Key Variables.*

Variable	Male Mean ± SD	Female Mean ± SD	t-value	p-value	Cohen's d
Psychosocial adaptation	4.02 ± 0.85	3.78 ± 0.91	2.45	0.015	0.27
Prosthesis satisfaction	3.95 ± 0.88	3.70 ± 0.95	2.10	0.036	0.27
Social support	4.05 ± 0.92	3.95 ± 1.05	1.20	0.231	0.10

Significant at $p < 0.05$

3.8. Correlation Analysis

Pearson correlation analysis demonstrated significant positive relationships among psychosocial adaptation, prosthesis acceptance, and perceived social support. Psychosocial adaptation showed a strong positive correlation with prosthesis acceptance ($r = 0.62$, $p < 0.01$). Likewise, perceived social support was positively correlated with psychosocial adaptation ($r = 0.58$, $p < 0.01$) and prosthesis acceptance ($r = 0.55$, $p < 0.01$).

Correlation Analysis

Table 8. *Correlation between Key Variables.*

Variables	Psychosocial Adaptation	Prosthesis Acceptance	Social Support
Psychosocial Adaptation	1.00	0.62**	0.58**
Prosthesis Acceptance	0.62**	1.00	0.55**

Variables	Psychosocial Adaptation	Prosthesis Acceptance	Social Support
Social Support	0.58**	0.55**	1.00

Correlation significant at p < 0.01

3.9. Predictors of Prosthesis Acceptance

Multiple linear regression analysis identified psychosocial adaptation (β = 0.41, $p < 0.001$), perceived social support (β = 0.29, $p < 0.001$), gender (β = 0.12, $p = 0.035$), and duration of prosthesis use (β = 0.18, $p = 0.001$) as significant independent predictors of prosthesis acceptance. The level of amputation was not a significant predictor ($p = 0.061$). The regression model explained 48% of the variance in prosthesis acceptance ($R^2 = 0.48$; adjusted $R^2 = 0.46$; $F = 31.42$, $p < 0.001$).

Multiple Regression Analysis

Table 9. *Predictors of Prosthesis Acceptance.*

Predictor Variable	β	Standard Error	t-value	p-value
Psychosocial adaptation	0.41	0.05	8.20	<0.001*
Social support	0.29	0.04	6.45	<0.001*
Gender	0.12	0.06	2.11	0.035*
Duration of prosthesis use	0.18	0.05	3.42	0.001*
Level of amputation	-0.09	0.04	-1.88	0.061

Model Summary: $R^2 = 0.48$; Adjusted $R^2 = 0.46$; $F = 31.42$; $p < 0.001$

4. Discussion

This study examined psychosocial adaptation and prosthesis acceptance among lower-limb amputees in Nigeria, with emphasis on gender differences and the role of social support. The findings are discussed in relation to existing literature.

The present study revealed that males constituted the majority of respondents (69.0%), while females accounted for 31.0%. This gender distribution is consistent with previous studies, which have reported that males are more frequently affected by limb amputation, largely due to higher exposure to road traffic accidents, occupational hazards, and high-risk activities [26, 27]. This pattern is also consistent with Nigerian reports of amputation patterns and rehabilitation challenges [5, 25, 27, 28]. Global and regional evidence on limb loss prevalence and patterns also supports the broader burden of amputation [1-4].

The age distribution showed that the majority of respondents were within the 31-45 years age group (37.6%), followed by those aged 46-60 years (28.0%), indicating that most participants were within the economically productive age group. This finding aligns with earlier reports suggesting that amputation disproportionately affects individuals in their active working years, thereby contributing to significant socioeconomic consequences [28].

In terms of marital status, the majority of respondents were married (57.1%), which may have implications for psychosocial support, as married individuals are more likely to receive emotional and practical assistance from spouses. Previous studies have shown that marital support significantly improves psychological adjustment and rehabilitation outcomes among amputees [8].

Regarding employment status, slightly more than half of the respondents were employed (53.3%), while 46.7% were unemployed. This indicates that although a substantial proportion of amputees remain economically active, nearly half face employment challenges, which may negatively impact psychosocial wellbeing and quality of life. Similar findings have been reported in previous studies, where unemployment rates among amputees ranged from 40-60%, reflecting barriers to workforce reintegration [28]. Broader rehabilitation literature similarly emphasizes the functional and psychosocial consequences of limb loss [14, 26].

The clinical profile of respondents showed that trauma was the leading cause of amputation (54.9%), followed by diabetes (23.5%), infection (13.3%), and other causes (8.3%). This is consistent with findings from developing countries, where trauma accounts for 50-70% of amputations, particularly due

to road traffic accidents and occupational injuries [29]. In contrast, studies from high-income countries often report diabetes and vascular diseases as the predominant causes [2], highlighting regional differences in etiology.

With respect to the level of amputation, below-knee amputations were more common (57.9%) than above-knee amputations (42.1%). This pattern is consistent with previous studies, which report that below-knee amputations account for approximately 55-65% of cases, largely due to better functional outcomes and surgical preference for limb preservation [30].

Regarding duration of prosthesis use, the majority of respondents had used their prostheses for more than one year, with 39.4% using them for 1-3 years and 39.9% for over three years. This suggests that most participants had adequate experience with prosthetic devices, thereby enhancing the reliability of their responses. Previous research indicates that individuals who have used prostheses for longer durations tend to demonstrate better adaptation and higher satisfaction levels [20].

The present study found that a majority of respondents demonstrated positive psychosocial adaptation, with approximately 75-80% of participants agreeing that they felt confident, socially accepted, and optimistic about the future. This suggests that most amputees were able to adjust emotionally and socially despite the challenges of limb loss.

This finding is consistent with previous studies. For instance, Murray et al. [7] reported that about 70% of amputees achieved moderate to high levels of psychological adjustment following rehabilitation. Similarly, Gallagher and MacLachlan [8] found that approximately 72% of amputees adapted positively over time, particularly when supported by effective coping strategies.

However, the present study also identified that about 20-25% of respondents experienced difficulties related to body image and social perception, indicating that not all individuals achieve optimal adjustment. This aligns with findings by Sinha et al. [28], who reported that up to 30% of amputees experience persistent body image disturbance and emotional distress.

The variation in psychosocial adaptation observed in this study supports the biopsychosocial model, which posits that adjustment outcomes are influenced by the interaction of biological, psychological, and social factors rather than physical condition alone [11].

User-centred prosthetic rehabilitation literature emphasizes the importance of function, participation, and individualized care [18, 20, 21].

This is comparable to findings by Resnik et al. [25], who reported that approximately 75-85% of amputees use their prostheses regularly. Similarly, Biddiss and Chau [20] found that about 80% of users reported functional benefits from prosthetic devices, although satisfaction varied across individuals.

Despite this high level of use, the present study found that about 25-30% of respondents expressed dissatisfaction, particularly regarding comfort and cosmetic appearance. This is consistent with Østlie et al. [17], who reported that 20-30% of amputees experience dissatisfaction or discomfort, which may lead to reduced use or abandonment. Evidence from prosthesis rejection studies also identifies comfort, function, and individualized prosthetic care as important determinants of continued use [19, 22].

The study demonstrated a strong positive correlation ($r = 0.62$) between psychosocial adaptation and prosthesis acceptance, indicating that individuals with better psychological adjustment are more likely to use and accept their prosthetic devices.

This finding is supported by Shanmugam et al. [14], who reported that over 60% of amputees with high psychological wellbeing demonstrated consistent prosthesis use. Similarly, previous studies have shown that individuals with positive self-image and emotional stability are more likely to integrate prosthetic devices into daily life [15].

Conversely, individuals experiencing psychological distress are less likely to use prostheses effectively, highlighting the need for integrated rehabilitation approaches.

The results showed that respondents experienced high levels of social support (mean $\approx 4.0/5$), with family support being the strongest. Furthermore, social support was significantly correlated with psychosocial adaptation ($r = 0.58$) and prosthesis acceptance ($r = 0.55$).

In Nigeria, extended family systems may provide an important source of support, although cultural stigma may sometimes limit social acceptance. Therefore, strengthening social support systems should be a key component of rehabilitation strategies.

These findings are consistent with Cohen and Wills [23], who demonstrated that social support plays a buffering role against stress. Empirical studies have also shown that individuals with strong social support are up to 50-60% more likely to achieve positive rehabilitation outcomes [23].

The study identified significant gender differences, with males showing slightly higher psychosocial adaptation scores (≈ 4.02) compared to females (≈ 3.78), and higher prosthesis satisfaction levels.

However, the findings also suggested that gender differences are influenced by sociocultural expectations. In Nigeria, societal norms often place pressure on men to fulfill provider roles and on women to maintain physical appearance and social identity. These expectations may shape how individuals respond to limb loss and rehabilitation.

These findings align with previous research. Nolen-Hoeksema [22] reported that women are more likely (by approximately 20-30%) to experience body image concerns and emotional distress following physical changes. Similarly, Wong et al. [31] found that men are more likely to prioritize functional independence and role performance, which may enhance adaptation. These observations should be interpreted alongside literature on sex differences in coping and gender-

related psychological responses [21-24, 31].

Overall, the findings of this study are consistent with global literature but show some contextual variations:

The psychosocial adaptation levels observed in this study (75-80%) align with previous reports (70-75%) [26, 27].

Prosthesis usage (77.3%) is comparable to global estimates (75-85%) [25].

Dissatisfaction rates (25-30%) are similar to earlier findings [17].

Social support influence is consistent with established theories [23].

Gender differences observed align with some studies but differ in magnitude due to cultural context [22, 31].

In Nigeria, amputee rehabilitation presents unique challenges such as: limited access to rehabilitation services, high cost of prosthetic devices and cultural stigma.

However, unlike many studies conducted in high-income settings, this study reflects the realities of a resource-constrained environment, where financial barriers, limited access to prosthetic services, and cultural stigma may influence outcomes more strongly.

4.1. Strengths and Limitations

A major strength of this study is its relatively large sample size, which increased the statistical power of the analyses and enabled meaningful comparisons between male and female participants. The use of standardized instruments, including the Trinity Amputation and Prosthesis Experience Scales and the Multidimensional Scale of Perceived Social Support, further strengthens the reliability of the findings. However, the cross-sectional design precludes causal inference, and the use of non-probability sampling may limit the generalizability of the findings to all lower-limb amputees in Nigeria. Additionally, self-reported measures are subject to recall and social desirability bias. Future longitudinal and multicenter studies using probability sampling are recommended to validate and extend these findings.

4.2. Clinical Implications

The findings have important implications for rehabilitation practice in Nigeria and similar resource-constrained settings. Prosthetic rehabilitation should extend beyond restoration of physical function to include structured psychological support, family engagement, peer support programs, and interventions that address body image and social participation. Policymakers should also prioritize improving access to affordable prosthetic services and expanding rehabilitation infrastructure to enhance long-term rehabilitation outcomes and quality of life for individuals living with limb loss.

5. Conclusion

This study demonstrated that psychosocial adaptation, prosthesis acceptance, and perceived social support are closely associated among lower-limb amputees in Nigeria. Most participants reported satisfactory psychological adjustment and regular prosthesis use, although significant gender differences were observed in psychosocial adaptation and prosthesis satisfaction. Psychosocial adaptation emerged as the strongest predictor of prosthesis acceptance, highlighting the importance of addressing emotional and social well-being alongside physical rehabilitation.

These findings support the adoption of comprehensive, patient-centered rehabilitation programs that integrate psychological counseling, family and community support, and gender-sensitive interventions with high-quality prosthetic care. Such multidisciplinary approaches are likely to improve prosthesis acceptance, functional independence, and overall quality of life among individuals with lower-limb amputation.

Future research should employ longitudinal, multicenter designs using probability sampling to evaluate changes in psychosocial adaptation over time and to establish causal relationships among psychosocial adaptation, social support, and prosthesis acceptance.

Abbreviations

MSPSS	Multidimensional Scale of Perceived Social Support
SPSS	Statistical Package for the Social Sciences
TAPES	Trinity Amputation and Prosthesis Experience Scales

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Author Contributions

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Data Availability Statement

The datasets generated and analyzed during the current study are available from the corresponding author upon reasonable request.

Conflicts of Interest

The authors declare that they have no competing interests.

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