

# Peer-mentorship among people with lower limb amputations living in small communities

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## Abstract

**Introduction:** Peer-mentorship, when a peer shares a connection to a group provides knowledge, empathy, and validation through the unique perspective of their lived experience of practical and social-emotional knowledge following disease or disability. However, there is a paucity of research on peer-mentorship among individuals with lower limb amputations particularly those who live in small communities. This study aimed to investigate peer-mentorship among individuals with lower limb amputations in small communities during pre-amputation procedures and adjustment to life post-amputation.

**Methods:** Qualitative description, semi-structured telephone interviews were conducted with peer-mentors or mentees who experienced lower limb amputation in a small community.

**Consumer and community involvement:** One member of the research team was a person with lived experience, and another member of the research team was a clinician (orthopaedic surgeon). Both team members contributed to the study concept, design and analysis of the data and have read and approved the final manuscript. The team member with lived experience additionally supported participant recruitment.

**Results:** Four themes emerged: ‘satisfying an unmet need’ explores the desire to learn from others who have similar experiences living with lower limb amputation; ‘improving independence’ describes the unique guidance offered by peer-mentors for returning to daily activities; ‘friendship’ considers peer-mentors’ therapeutic delivery including its long-lasting guidance and connection; ‘advocating for support and resources’ examines how peer-mentors fulfil supportive roles such as health-care navigation.

**Conclusion:** Results demonstrate peer-mentorship’s role in improving independence and social support and providing advocacy during adjustment to lower limb amputation among people residing in small communities.

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## PLAIN LANGUAGE SUMMARY

People who have had their leg amputated need support programs. This is very true for people living in small communities. In this study, we talked to people who have had a leg amputated and who live in a small community. We wanted to know their thoughts about peer-support. Peer-support is when someone who has a leg amputation provides support to others who also have a leg amputation. We asked people: How did peer-support help you get ready for your amputation? How did peer-support help you after your amputation? People said that peers provided education and advice. People also talked about peers being a friend. Overall, peer-support was helpful.

## KEYWORDS

activities of daily living, amputations, participation, psychosocial, recovery, rehabilitation, rural health care

## 1 | INTRODUCTION

Individuals with lower limb amputations experience both physical and psychosocial challenges which impact their activities of daily living, including but not limited to reduced mobility, increased pain, social isolation, and depression (Suckow et al., 2015). Despite advancements in clinical practice that have led to improved physical client outcomes, there remains a need to support psychological coping and adjustment to life post-amputation (Reichmann & Bartman, 2018); which is likely to be magnified in small communities where there are discrepancies in health-care opportunities and delivery (Hameed et al., 2010; Karunanayake et al., 2015).

Peer-mentorship is when a peer who shares a connection to a group provides knowledge, empathy, and validation through the unique perspective of their lived-experience with a similar phenomenon (Truong et al., 2019). Existing research, combined with an abundance of unpublished anecdotal evidence, indicates positive psychosocial effects of peer support in individuals with limb amputation (Brusco et al., 2023; Hutchison et al., 2023, 2024; Reichmann & Bartman, 2018) and is viewed as an effective psychosocial component of the rehabilitation process (Reichmann & Bartman, 2018). The majority of this work, however, has been completed among individuals living in urban locations.

Between 2006 and 2011, more than 44,000 Canadians reported living with a lower limb amputation (Imam et al., 2017). Although there are numerous causes for lower limb amputation, individuals who experience any form of limb loss are susceptible to an intersection of physical, functional, and psychological challenges. Following the initial subacute pain resultant of wound healing, limb amputation is often accompanied by phantom

### Key Points for Occupational Therapy

- Occupational therapists are well-positioned to refer participants to peer-mentorship programs by identifying those who may benefit from social-emotional support or peer education regarding limb loss.
- Peer mentorship programs provide opportunities to improve occupational therapy service delivery by offering lived-experience on the completion of daily occupations such as functional mobility or personal care with limb loss that cannot typically be offered by a health-care practitioner.
- As peer mentors and occupational therapists are often working towards common goals, including that of daily living participation, occupational therapists may consider collaborating with peer mentors to enhance the recovery outcomes of individuals experiencing lower limb amputation in small communities.

limb pain (PLP) and other chronic pain concerns, such as mirror image pain presenting in the contralateral limb (Larbig et al., 2019). Suckow et al. (2015) found that the presence of pain negatively influenced mobility, and therefore, the participants' quality of life decreased along with their sleep and walking capacity. Further, a systematic review inferred that decreased function following a lower limb amputation also resulted in the loss of occupation, including work, and previously enjoyed leisure

activities (Murray & Forshaw, 2013). Despite these findings, there continues to be a lack of psychosocial approaches following amputation (Pedras et al., 2020), and consequently, this gap in approach has resulted in the development of comorbid conditions, such as anxiety and depression, negatively impacting activities of daily living (Pedras et al., 2020). These concerns were described in literature as the feeling of being alone, sad, and isolated with a lack of independence, often spending days without leaving the home environment (Suckow et al., 2015).

Individuals with lower limb amputation may find social isolation less anxiety provoking than facing the anticipated judgement and fear of social rejection (Liu et al., 2010; Murray & Forshaw, 2013). Previous research has concluded that poor ambulatory skills (Grzebień et al., 2017; Suckow et al., 2015; Washington & Williams, 2016), pain (Grzebień et al., 2017; Murray & Forshaw, 2013), and a reduction in social participation (Senra et al., 2011) are associated with depressive symptoms in individuals with lower limb amputation. Ensuring healing of the residual limb is one significant factor in many rehabilitation programs. However, healing in other areas of life, including emotional adjustment and psychosocial wellbeing has received less recognition (Reichmann & Bartman, 2018).

In addition to the physical, functional, and psychosocial challenges of adjusting to a lower limb amputation, the complexities of residing in small communities (a population of <29,999) (Government of Canada, 2017) present unique barriers to accessing health care. Many individuals residing in small communities require travel to urban locations (Karunanayake et al., 2015), which can be expensive. Small community residents with lower limb amputation have expressed that this lack of connection with health-care professionals is a disadvantage to recovery (Naidoo & Ennion, 2019). Particularly, individuals with a mental health diagnosis, common in those with a lower limb amputation (Grzebień et al., 2017; Suckow et al., 2015), determined that a health-provider with mutual small community experience would best support their recovery journey (Cheesmond et al., 2020). Thus, there is a need for therapeutic relationships that incorporate a shared understanding of navigating health adjustments in small communities.

Peer-mentorship is a meaningful solution in resource constrained environments to improve psychosocial outcomes and balance health-care costs (Reichmann & Bartman, 2018). Although research demonstrates the advantageous impact of peer-mentorship in health contexts, there has been limited research published on the value of the connection of peers who experience lower limb amputation (Reichmann & Bartman, 2018). Peer-

mentorship provides a safe space for those coping with the new challenges of limb loss to receive meaningful social-emotional support (Liu et al., 2010; Murray & Forshaw, 2013; Valizadeh et al., 2014) and practical strategies regarding mobility and prosthetic use (Murray & Forshaw, 2013; Richardson et al., 2020). As research reveals, 'successful recovery depends not only on improving physical outcomes but also on recognizing and addressing the psychological and social needs of the patient in an effective and efficient manner' (Archer et al., 2010, p. 779). It has been found that participation in peer-mentorship for individuals with lower limb amputation can help meet the unique psychosocial needs that cannot be fulfilled by medical personnel; these needs include fear, anxiety, future concerns, and expectations of life after amputation (Liu et al., 2010).

Community-based adjustment and psychosocial programs are needed for all people with lower limb amputation, and this is especially true for people living in small communities due to the barriers of transportation, increased physical and mental health risk factors, and lack of support. Therefore, the purpose of this study was to explore the lived experience of individuals with lower limb amputation living in small communities who have received peer-mentorship. Specifically, we sought to address the following questions: What is the impact of peer-mentorship during the pre-amputation process and the adjustment to life post-amputation? We anticipate that this study will provide valuable evidence about the role of peer-mentorship on the recovery and adjustment to life after lower limb amputation among people living in small communities. It is anticipated that this contribution will help address a gap in research to improve advocacy efforts for peer-mentorship in small communities, reducing the disparity of needs that have gone unmet.

## 2 | METHODS

### 2.1 | Study design

This study is reported according to the Consolidated Criteria for Reported Qualitative Research (Tong et al., 2007) and utilises a qualitative description design (Neergaard et al., 2009). Ethical approval for this study was obtained from the University of British Columbia's Behavioural Research Ethics Board [H20-01814].

### 2.2 | Participants and recruitment

Participants were required to meet the following inclusion criteria: (i) experienced a lower limb amputation

operatively or traumatically, (ii) experienced peer-mentorship in a small community, (iii) lives or lived in a small British Columbia community during participation in the peer-mentorship, (iv) aged 19 years and older and (v) deemed medically stable (e.g., no uncontrolled symptoms and conditions). Individuals were excluded from the study if limb loss was congenital, as the intent was to learn the psychosocial impacts pre- and post-amputation or if they received peer-mentorship but resided in an urban location at the time of the amputation. Recruitment was obtained using snowball sampling from a coordinator who fulfilled the role of a peer-mentor as well as an orthopaedic surgeon, who was familiar with peer-mentorship programming and referred patients to a peer-mentor. These informants connected with previous and current participants from an existing, informal, peer-mentorship program within three small communities in British Columbia, introducing the study, and providing study information to those interested.

The peer-mentorship program in which the participants had participated was informal and delivered on a one-to-one basis allowing sessions to be individualised to each participant's needs. Many participants sought mentorship related to activities of daily living including topics such as mobilisation with limb loss and activity adaptation. Others sought mentorship to meet social-emotional needs including fear, grief, and expectations of life after amputation. The duration of participation was based on individual needs and ranged from one session of mentorship to a life-long connection, during which the mentor remained available for ongoing questions and support as the participant learned to adjust to limb loss throughout their lifetime. The mentor provided services on a volunteer basis and did not complete formalised training to provide mentorship. The mentor shared expertise and knowledge translation based on their lived experience with lower limb amputation.

## 2.3 | Data collection

A semi-structured interview guide was developed to explore participant experiences and perceptions of peer-mentorship, including questions regarding shared practical strategies, psychosocial impacts, adjustments to returning to a small community, established social supports, and health-care experiences, both pre-amputation and during rehabilitation. Specific interview questions included 'What, if any, challenges and/or barriers did you experience following the amputation? How would you describe the differences, if any, between your rehabilitation experience and your peer-mentorship experience? (and) What supports, if any, do you feel were missing in your rural community?'

The semi-structured initial interview questionnaire was initially designed by the two primary researchers following an in-depth literature review and conversation with the research team, including the peer mentor. After this information-gathering process, the two primary researchers were able to identify possible areas of gaps in knowledge, generate the research objective, and curate interview questions targeting the objective. The drafted semi-structured interview questionnaire was emailed to all members of the research team and discussed over Zoom, where feedback was provided, and edits were made. This process occurred one more time before finalising the semi-structured interview script. The first two interviews were co-facilitated by the same two primary members of the research team, both taking reflective notes separately. Once these two interviews were complete, the entire research team was consulted via Zoom. At this time, no edits were suggested, and the team agreed to continue.

Interviews were conducted via telephone or video conferencing (Zoom Video Communications) during COVID-19 conditions and were audio-recorded. During the interview, a questionnaire was also administered to obtain sociodemographic information (Table 1). The interviews were conducted over 6 months and averaged between 60 and 90 minutes. The first interview was co-facilitated by two trained members of the research team, and subsequent interviews were then completed individually to promote triangulation of researchers. Reflective notes were written directly following each interview to ensure confirmability, and the research team debriefed bi-weekly to share interpretations, reduce potential bias, and discuss reflections on gathered information. Participants received a \$15.00 stipend to offset any time commitments associated with participation.

By the seventh and eighth interviews, the research team was unable to identify new codes and themes, and as such, it was deemed that data saturation had been reached.

## 2.4 | Positionality statement

The two primary researchers who interviewed and analysed the data were educated student occupational therapists completing their graduate studies at the University of British Columbia. Both researchers identified as White/Caucasian women and were younger than 30 years of age. One grew up in an urban setting while the other in a rural setting. As one of the researchers had lived experience residing rurally, this allowed her to develop trust and a shared understanding towards experiences that can be unique to small community living.

Neither researcher had lived experience with a lower limb amputation of their own. However, as student occupational therapists, both brought experience working alongside individuals with diverse physical, cognitive, and psycho-social health conditions providing a supportive space for individuals to express their thoughts, feelings, and lived-experiences. Other members of the research team included two researchers from the University of British Columbia with a special interest in mobility disability, one orthopaedic surgeon with interest in recovery post-amputation, and one member with lived experience of a lower limb amputation and interest in peer support and peer recovery both pre- and post-amputation.

## 2.5 | Data analyses

Following the inductive nature of this study, the data were transcribed verbatim and analysed thematically. The thematic analysis followed Braun and Clarke's (2006) step by step guide: (i) becoming familiar with the data; (ii) generating initial codes; (iii) searching for themes; (iv) reviewing themes; and (v) defining themes. Both interviewers read the transcripts several times to understand the participants' experiences and meaning in each statement. The first two transcripts were coded individually by the dyad. The open codes were then discussed and agreed upon collaboratively. A coding scheme was subsequently presented to the research team based on these findings and discussed until consensus was reached to formulate a code guide. This code guide was then applied to the remaining transcripts and was revised as new codes were identified. The guide was frequently discussed to ensure recurring consensus. Cumulatively, the codes were analysed and compared to create themes that

received final approval from the research team. The team also attempted to share these themes with the study participants to incorporate reflexive participant collaboration. One study participant was available to participate in this process and reviewed the themes, providing input and knowledge from a lived-member perspective.

## 3 | RESULTS

Eight participants were recruited who either received peer-mentorship ( $n = 7$ ) or were a peer-mentor themselves ( $n = 1$ ). The results include findings from both the perspectives of the mentees and the mentor. Participants were predominantly older than age 50 ( $n = 7$ ), male ( $n = 5$ ), and retired ( $n = 6$ ). Lastly, 50% ( $n = 4$ ) of participants reported the cause of their limb loss to be traumatic while the other 50% reported their cause to be vascular. Participant characteristics are further detailed in Table 1.

Our thematic analysis revealed four overarching themes: 'satisfying an unmet need', 'improved independence', 'friendship', and 'advocating for support and resources'. Two subthemes, 'practical strategies' and 'psychosocial supports' were further elaborated upon under 'improved independence'. An overview of themes and representative quotes may be found in Table 2.

### 3.1 | Satisfying an unmet need

This theme explores how peer-mentorship satisfies a desire to learn from others with a lower limb amputation who live in a small community. Although family, friends, and medical experts were reported as important resources in decision making to inform surgery, extend empathy,

TABLE 1 Participant characteristics.

#	Age (years)	Sex	Marital status	Living situation	Highest level of education	Employment status	Total household income	Cause of amputation
1	Older than 50	M	Married	With spouse	Post-secondary	Retired	>50,000	Traumatic
2	Older than 50	F	Married	With spouse	Post-secondary	Retired	>50,000	Vascular
3	Older than 50	M	Separated	With family	Post-secondary	Disability leave	>50,000	Vascular
4	Older than 50	F	Married	Alone	High-school	Retired	>20,000	Vascular
5	Between 35 and 50	M	Separated	With partner	Post-secondary	Part-time	20,000–50,000	Traumatic
6	Older than 50	F	Divorced	With common-law	High-school	Retired	<20,000	Vascular
7	Older than 50	M	Married	With spouse	Grade 11	Retired	20,000–50,000	Traumatic
8	Older than 50	M	Widowed	Alone	Post-secondary	Retired	Deferred	Traumatic



TABLE 2 Themes and quotes.

Main theme	Sub-theme	Quotes
Satisfying an unmet need		<ul style="list-style-type: none"> <li>Everybody's, you know, phenomenal, but, as I sit here by myself and make this decision, I have questions in my head that I won't ask anybody because, one, I don't know who to ask and, two, I don't know if I want to ask, and yet here's this stranger [peer-mentor] who phones, his situation is aligned with mine [...], it left me so that I had somebody suddenly who knew where I was and could answer those questions and made me feel comfortable enough, just by his presentation and his demeanor. (Participant #7)</li> <li>'I was trying to talk to everyone about this stuff', questioning 'where was I going to go, what was I going to do, what am I going to do for the rest of my life, how am I going to work? [participant #5]</li> <li>They don't have that time to spend with you to alleviate those things about what's going to happen once you leave the hospital, right? And that's where the peer-mentorship comes in. (Participant #3)</li> <li>There aren't that many amputees around in a little town, two or three perhaps. (Participant #1)</li> <li>What I found frustrating was that there was absolutely nothing available to me. And so, then it kind of evolved from there, [...] my working with other patients, I had a feeling of you know the helpless thing having no information, nothing available, where I've known what I wanted and it helps me knowing what the other patients want. (Participant #8)</li> <li>Difficult (Participant #6)</li> <li>Invaluable because it relieves a psyche part of the issue. Without it you'd be kind of hanging out in the middle of nowhere.' (Participant #7)</li> </ul>
Improving Independence	Practical strategies	<ul style="list-style-type: none"> <li>Bathroom questions were probably one of my bigger ones. Baths, [using] the toilet [...] and [peer-mentor] was straight up with his answers, and his final answer was, 'If you have any more questions or you have anything that comes up, phone me. We'll work through it'. (Participant #7)</li> <li>It's just little tiny questions that you might have, like, how do you get off the toilet? Or how do you get into the shower? Do you have shower bars? Or you know, how do you climb many stairs? What do you do on the ice? [...] I knew that I could get those [answers]. (Participant #3)</li> <li>I had questions about things [such as] living with a prosthetic [...] and I had a great deal of phantom pain [...] and [the peer-mentor] and I could discuss things like that and I couldn't discuss things like that with anybody else because they've never experienced that, and so it was very, very valuable to me. (Participant #1)</li> <li>They want to know how to be able to drive their vehicle after their amputation, [they ask] how I do it, and so I tell them what my story is, how I do it, that's all I can relate to there's no [book] on driving with one leg. (Participant #8)</li> </ul>
	Psychosocial supports	<ul style="list-style-type: none"> <li>[He] could see that I was a bag of anxiety and so he showed me his prosthetic leg, he took it off and showed me how it worked and what it was all about, and it was good because it kind of eased my anxiety thinking yeah maybe I'll still be able to walk and get around. (Participant #5)</li> <li>The mentorship is probably the biggest positive [...] because my biggest fear being my granddaughter, [peer-mentor] said, 'talk to her about it. Kids are great, they understand. They don't question your prosthetic.' [...] (Peer-mentor) telling me about him showing his foot to other kids and how accepting they were of it made me feel comfortable going ahead with it. (Participant #7)</li> <li>When you have someone that's a fellow amputee and they're up walking around [...] climbing up three flights of stairs, then you have no more doubts in your mind that you're going to be able to return to as close to what you had before amputation [...] because you're looking at someone that's doing it (Participant #6)</li> <li>[peer-mentor] talked about how he golfed 18 holes [...] and that he walked, golfed, and did everything that normal people do, and basically, I think that peer-mentorship helped because if he could do it, I certainly thought I could. (Participant #1)</li> </ul>

TABLE 2 (Continued)

Main theme	Sub-theme	Quotes
Friendship		<ul style="list-style-type: none"> <li>You don't need an appointment. You just pick up the phone, and if they're not on the end of it, in [peer-mentor]'s case, its return call is always within [...] one day at the very outside, but usually he calls back within two to four hours. (Participant #7)</li> <li>My husband and I, and [peer-mentor] and his wife would just have a nice visit when they came (Participant #2)</li> <li>I've met with [peer-mentor] a great many times, he's become something of a friend. (Participant #1)</li> <li>There is the singing group that will come entertain us and that's the time [peer-mentor] would also come to attend (Participant #4)</li> <li>Oh, yeah. In fact, he was here not very long ago (Participant #2)</li> <li>Oh absolutely, we run into each other occasionally. He's got a thing for dairy queen onion rings you know! (Participant #6)</li> <li>For one reason or another, I do become closer with them (Participant #8)</li> <li>He just encourages me, [...] and it takes a special person too, I think to do it (Participant #2)</li> <li>He's very talented, he's an extremely good listener, and he really exudes calmness and has a serenity about him (Participant #6)</li> <li>I told her the exercises she should do, and every day I'd go to the hospital to see her and she'd just be smiling like her best friend arrived. And it gave me a good feeling to know she was so happy to see me. (Participant #8)</li> <li>I get a great satisfaction when somebody a year later or two years later lets me know what an effect, I had on them or their family, you know it's kind of your pay back is the feeling you get from helping out other people you know? I think that's really the only way of summing it up. (Participant #8)</li> </ul>
Advocating for support and resources		<ul style="list-style-type: none"> <li>[peer-mentor] told me about [...] the prosthetist [...] and what a good [prosthetist] he was, and that he is easy to talk to, which he is. (Participant #5)</li> <li>You know the doctor and [peer-mentor] always talked about what to do with me (Participant #4)</li> <li>So [peer-mentor] told me how much help they got from the government and that they even helped build a new house so [peer-mentor] could use their wheelchair in there. I guess it just made me realize that there is still a future, I can still have a life. (Participant #5)</li> <li>A lot of them don't know if you have the doctor fill out a form. It makes a huge financial difference on their annual income tax. So, in most cases I tell them how to fill it out or help fill it out for them and in one case [...] they got over \$10,000 of [financial compensation] [...] I got them on that, that's mentoring, eh? (Participant #8)</li> <li>I say to them [...] you meet with your doctor and you tell them under no circumstance am I coming to you. And they say oh I didn't know I could do that, so that becomes another form of my mentoring. (Participant #8)</li> </ul>

and provide practical support, all eight participants still identified a need to speak to someone who could offer mutual understanding of limb loss. Participant #7 summarised the unique relief felt after speaking with a peer-mentor when making the decision to amputate:

Everybody's, you know, phenomenal, but, as I sit here by myself and make this decision, I have questions in my head that I won't ask anybody because, one, I don't know who to ask and, two, I don't know if I want to ask, and yet here's this stranger [peer-mentor] who phones, his situation is aligned with mine [...], it left me so that I had somebody

suddenly who knew where I was and could answer those questions and made me feel comfortable enough, just by his presentation and his demeanour.

One participant (#5) shared the sense of urgency to find someone with mutual experience who could offer advice related to what life would look like with an amputation, stating: 'I was trying to talk to everyone about this stuff', questioning 'where was I going to go, what was I going to do, what am I going to do for the rest of my life, how am I going to work?' Almost all participants expressed similar queries, followed by stating

appreciation and value in speaking with a peer-mentor. Additionally, participants identified the need for medical expertise but proposed that 'they don't have that time to spend with you to alleviate those things about what's going to happen once you leave the hospital, right? And that's where the peer-mentorship comes in' (Participant #3).

Participants noted the challenge of acquiring guidance from a fellow amputee within a small community. Participant #1 shared that 'there aren't that many amputees around in a little town, two or three perhaps'. In particular, this unmet need motivated one of the participants (#8) to become a peer-mentor themselves:

What I found frustrating was that there was absolutely nothing available to me. And so, then it kind of evolved from there, [...] my working with other patients, I had a feeling of you know the helpless thing having no information, nothing available, where I've known what I wanted, and it helps me knowing what the other patients want.

Considering the limited availability of resources, all but one participant communicated that managing life post-amputation would be 'difficult' without the peer-mentorship they had received (Participant #6). Participant #7 elaborated that being a recipient of peer-mentorship was 'invaluable because it relieves a psyche part of the issue. Without it you'd be kind of hanging out in the middle of nowhere.' Evidently, many participants were extremely grateful to have the opportunity of being mentored and felt that without it, they would have experienced adverse recovery outcomes.

### 3.2 | Improving independence

In this theme, participants described the unique guidance offered by peer-mentors to enable independence in daily activities. Two sub-themes were developed: 'practical strategies', and 'psychosocial supports'.

#### 3.2.1 | Practical strategies

According to participants, peer-mentorship offered incomparable guidance to perform daily tasks such as functional mobility, community navigation, and pain management. For example, Participant #7 shared

Bathroom questions were probably one of my bigger ones. Baths, [using] the toilet [...]

and [peer-mentor] was straight up with his answers, and his final answer was, 'If you have any more questions or you have anything that comes up, phone me. We'll work through it.'

Much of the advice from peer-mentors focussed on occupational performance issues or environmental factors that enabled independence. Participant #3 indicated

It's just little tiny questions that you might have, like, how do you get off the toilet? Or how do you get into the shower? Do you have shower bars? Or you know, how do you climb many stairs? What do you do on the ice? [...] I knew that I could get those [answers].

In addition, many participants experienced ongoing pain that negatively impacted participation in meaningful activities. Peer-mentorship was able to offer practical strategies to alleviate this pain, coupled with a sense of validation. Participant #1 emphasised

I had questions about things [such as] living with a prosthetic [...] and I had a great deal of phantom pain [...] and [the peer-mentor] and I could discuss things like that and I couldn't discuss things like that with anybody else because they've never experienced that, and so it was very, very valuable to me.

Furthermore, driving was commonly identified as a valued occupation. Participants indicated that this experience was supported by peer-mentors who had already developed adaptive strategies for driving. One participant (#8) who provided peer-mentorship disclosed that 'they want to know how to be able to drive their vehicle after their amputation, [they ask] how I do it, and so I tell them what my story is, how I do it, that's all I can relate to there's no [book] on driving with one leg.'

#### 3.2.2 | Psychosocial support

In addition to practical strategies to improve independence, participants indicated that peer-mentorship provided psychosocial support that enabled improved reassurance, motivation, and self-efficacy. Many participants disclosed experiencing fear and uncertainty towards what abilities and life may look like after their amputation. However, all eight participants highlighted





reassurance as an integral component to alleviating this uncertainty. Participant #5 shared

[He] could see that I was a bag of anxiety and so he showed me his prosthetic leg, he took it off and showed me how it worked and what it was all about, and it was good because it kind of eased my anxiety thinking yeah maybe I'll still be able to walk and get around.

Furthermore, peer-mentorship also enabled a sense of acceptance and self-efficacy, encouraging the return to valued roles and social networks. This sharing of lived experience was foundational in normalising the process of amputation:

The mentorship is probably the biggest positive [...] because my biggest fear being my granddaughter, [peer-mentor] said, 'Talk to her about it. Kids are great, they understand. They don't question your prosthetic.' [...] [Peer-mentor] telling me about him showing his foot to other kids and how accepting they were of it made me feel comfortable going ahead with it. (Participant #7)

Participants reported that seeing an individual with an amputation engage in valued activities contributed to forming new perspectives regarding self-efficacy and visual representations of realistic goals following amputation. Participant #6 shared

When you have someone that's a fellow amputee and they're up walking around [...] climbing up three flights of stairs, then you have no more doubts in your mind that you're going to be able to return to as close to what you had before amputation [...] because you're looking at someone that's doing it.

Additionally, one participant (#1) indicated that peer-mentorship improved self-belief in their ability to return to hobbies and interests sharing '[peer-mentor] talked about how he golfed 18 holes [...] and that he walked, golfed, and did everything that normal people do, and basically, I think that peer-mentorship helped because if he could do it, I certainly thought I could'.

### 3.3 | Friendship

This theme examines how peer-mentorship incorporates friendship to provide the unique service of informal,

long-lasting accessible guidance, mutual trust, and empathy. All participants described their peer-mentor as effortlessly available and accessible, similar to that of a friend:

You don't need an appointment. You just pick up the phone, and if they're not on the end of it, in [peer-mentor]'s case, its return call is always within [...] one day at the very outside, but usually he calls back within two to four hours. (Participant #7)

Participants also noted the effective service peer-mentorship offered, such as including family members, 'my husband and I, and (peer-mentor) and his wife would just have a nice visit when they came' (Participant #2). As a result of accessible, consistent, and informal means of support, participants came to consider their peer-mentor as a friend. Participant #1 stated, 'I've met with [peer-mentor] a great many times, he's become something of a friend'. Other participants shared that peer-mentorship promoted a sense of normalcy by attending informal social activities 'there is the singing group that will come entertain us and that's the time (peer-mentor) would also come to attend' (Participant #4).

Additionally, the longevity of friendship that develops between a peer-mentor and mentee was spoken of by many. Participant #2 stated their frequent connection following many years of friendship, 'Oh, yeah. In fact, he was here not very long ago' while Participant #6 shared their casual gatherings, 'Oh absolutely, we run into each other occasionally. He's got a thing for Dairy Queen onion rings you know!'. Without directly articulating the reason, Participant #8 noted the development of friendship throughout their provision of peer-mentorship, 'for one reason or another, I do become closer with them'.

Most participants considered the empathetic and encouraging personality of their peer-mentor to be a qualifier for the effectiveness of the friendly service. Participant #2 revealed, 'He just encourages me, [...] and it takes a special person too, I think to do it'. This distinctive personality was further described by Participant #6 to encompass active listening and a peaceful presence, 'he's very talented, he's an extremely good listener, and he really exudes calmness and has a serenity about him'.

Although the participants have acknowledged the substantial impact of peer-mentorship on their lives, Participant #8 spoke of the fulfilment gained from being a mentor. Examples they shared included the intimate bond created with mentees, where friendships arose, and successes were celebrated:

I told her the exercises she should do, and every day I'd go to the hospital to see her, and she'd just be smiling like her best friend arrived. And it gave me a good feeling to know she was so happy to see me.

Participant #8 continued that while in-the-moment victories are meaningful, the ultimate sense of fulfilment comes from imparting a lasting impact on another's life:

I get a great satisfaction when somebody a year later or two years later lets me know what an effect, I had on them or their family, you know it's kind of your pay back is the feeling you get from helping out other people you know? I think that's really the only way of summing it up.

### 3.4 | Advocating for supports and resources

In this theme, participants highlighted occurrences in which peer-mentors fulfilled supportive roles such as navigating health-care services and connecting community supports. One participant (#5) stated '[peer-mentor] told me about [...] the prosthetist [...] and what a good [prosthetist] he was, and that he is easy to talk to, which he is.' Another participant (#4) stated 'you know the doctor and [peer-mentor] always talked about what to do with me' explaining how a peer-mentor was available to participate in discussions with members of the participant's health-care team. Given this support, participants were able to obtain guidance based on the perspective of someone who had experienced similar needs.

Participants also indicated that without peer-mentorship, they received limited information regarding governmental or financial support programs to enable their recovery and offset economic health-care costs. For example, Participant #5 indicated:

So [peer-mentor] told me how much help they got from the government and that they even helped build a new house so [peer-mentor] could use their wheelchair in there. I guess it just made me realise that there is still a future, I can still have a life.

Further, peer-mentors themselves are aware that there is limited education available on resources following a change in health. As a result, peer-mentors ensure the inclusiveness of this information during their

mentoring. Participant #8 who identified as a peer-mentor indicated:

A lot of them don't know if you have the doctor fill out a form. It makes a huge financial difference on their annual income tax. So, in most cases I tell them how to fill it out or help fill it out for them and in one case [...] they got over \$10,000 of [financial compensation] [...] I got them on that, that's mentoring, eh?

Peer-mentors also advocated for equitable health-care treatment based on what they had learned during their personal recovery journey. For example, peer-mentors educated mentees on the importance of receiving community-care services in their homes to reduce mobility demands after a recent amputation. Participant #8 shared

I say to them [...] you meet with your doctor, and you tell them under no circumstance am I coming to you. And they say oh I didn't know I could do that, so that becomes another form of my mentoring.

## 4 | DISCUSSION

This study revealed qualitative evidence on peer-mentorship among small community-dwelling individuals living with a lower limb amputation. Peer-mentorship in small communities was recognised as an effective means of psychosocial support throughout the amputation process, addressing the limited evidence on interventions to support psychological coping and adjustment to life post-amputation (Reichmann & Bartman, 2018). Satisfying the unmet need to speak with an individual who shared a mutual understanding of lower limb amputation while simultaneously offering a trusting friendship, peer-mentorship created a comfortable and safe space to confide the challenges of living with an amputation. In addition, peer-mentorship displayed a pivotal role in health-care advocacy, using previous experience to ensure connection to resources and service providers that adequately support their mentee's physical and mental wellbeing.

Confirming Lui et al.'s findings (Liu et al., 2010), participants discerned that while their friends, family, and medical professionals provided exceptional support, a peer-mentor's practical guidance and authentic understanding about the grief of limb loss were unmatched. Similarly, a study interviewed eight peer-mentors for

individuals with a lower limb amputation and determined that while participants acknowledged the importance of formal medical services, peer-mentorship's unique support using the wisdom of lived experience was an imperative contribution to health care (Richardson et al., 2020). Other findings (Dillon et al., 2020) have also identified that accessible information regarding recovery outcomes and risks, combined with peer support and conversations with health-care providers, help bridge the gap of uncertainty for those following partial foot amputations. Considering the limited amount of published evidence demonstrating the psychosocial effects of peer-mentorship in individuals with lower limb amputation (Reichmann & Bartman, 2018), our findings propose clarity to this service's substantial impact and necessity as a complementary intervention to the physically focussed rehabilitation process.

In addition to small communities experiencing reduced access to family physicians and medical specialists (Kapral et al., 2019), participants in this study also expressed the substantial lack of peer-mentorship available while residing in smaller communities. Consequently, this combination of reduced health-care access (Kapral et al., 2019) and a scarcity of peer-mentorship for lower limb amputation (Truong et al., 2019), is likely to disadvantage recovery. Individuals with lower limb amputation have expressed that a lack of connection with health-care professionals can act as a barrier to achieving their rehabilitation goals (Naidoo & Ennion, 2019). These findings are significant to note as the opportunity to access rehabilitation following a lower limb amputation is closely correlated to positive quality of life outcomes (Grzebień et al., 2017).

Furthermore, corresponding with published findings (Truong et al., 2019), participants in our study also highlighted unique, beneficial modalities of peer-mentorship, including emotional and practical support in navigating similar challenges through reframing perspectives, modelling behaviours, and sharing coping skills. Within our study, these modalities improved levels of independence and enabled participants to return to meaningful daily tasks and roles innate to their well-being. For example, through mentorship and modelling of practical strategies, many participants learned how to return to driving, apply for financial support, adjust to prosthesis use, and develop functional mobility techniques to navigate their home environments. This finding aligns closely with previous research in which peer-mentorship enabled participants to adjust to moving around with their new prosthetic limb and ensured safe use (Murray & Forshaw, 2013; Richardson et al., 2020). However, our study provides the addition of a small community perspective and the practical strategies required

for integration within these contexts, often neglected and limited in past studies (Reichmann & Bartman, 2018).

Additionally, participants disclosed an evident sense of trust to discuss complex topics with their peer-mentor, including challenges with toileting, pain, and fear of social judgement due to sharing commonalities and a guaranteed empathetic understanding. Participants highlighted feeling reassured that they would have access to someone who could answer their questions promptly, regardless of the nature of the question. Peer-mentorship's impact on improving functional participation is substantial as previous research indicates that decreased function following lower limb amputation also results in the loss of occupation, including work, and previously enjoyed leisure activities (Murray & Forshaw, 2013). Therefore, the offering of lived experience as a teaching tool during community reintegration can be an effective intervention for preserving participation following lower limb amputation.

The development of self-efficacy, enabled by peer-mentorship interwoven into each participant's experiences, was labelled as pivotal in adjusting to life after amputation. As Archer et al. (2010, p.779) stated, 'successful recovery depends not only on improving physical outcomes but also on recognising and addressing the psychological and social needs of the patient effectively and efficiently.' Comparatively, a lack of psychotherapeutic approaches after amputation can result in less protective features against the secondary development of anxious and depressive symptoms, negatively impacting activities of daily living (Pedras et al., 2020). Participants aligning with these past findings disclosed that building acceptance and self-efficacy enabled improved motivation and helped to prevent adverse psychological outcomes while adjusting to lower limb amputation. This belief was instilled by the empathetic nature and reassurance that a peer-mentor was able to verbally provide and visually demonstrate through their own abilities and experiences. This finding aligns with the integral theoretical underpinnings that self-efficacy can be modified through vicarious learning and verbal persuasion (Nabavi, 2012).

Uniquely, our study revealed that friendship could be a natural means of delivering peer-mentorship, a novel concept in the current literature. A study examining the definition of friendship found that participants aged 55–87 living in North America indicated key determinants to include self-disclosure, sociability, trustworthiness, day-to-day assistance, shared activities, and loyalty (Adams et al., 2000). Comparably, all participants described their peer-mentor as available and accessible for frequent engagement in meaningful conversations, commonly focussed on the mutual self-disclosure of lived experience with lower limb amputation. Additionally, the peer-

mentor offered loyal, day-to-day assistance, using a combination of telephone calls and face-to-face socialising, often being acknowledged by participants for their 'faithfulness' and commitment to the mentee's psychological wellbeing and recovery process.

As identified by all participants, mutual understanding and encouragement were a common determinant for the efficacy of peer-mentorship, an arguably pivotal concept relevant to developing trust and friendship. Research has identified that support networks are key to improving social and community participation for individuals experiencing lower limb amputations (Keeves et al., 2023). Several studies have inferred that peer mentors are well-situated to become these support networks through their unique ability to understand and respond to the complex challenges faced by mentees, as their validation of experience results in a sense of belonging and reduced loneliness (Rahimi et al., 2019; Richardson et al., 2020; Truong et al., 2019). For most participants, the friendship built with their peer mentor continued beyond the extent of their everyday needs, often connecting to share a coffee and life update. Additional research (Richardson et al., 2020) revealed similar findings, stating that some of their peer-mentor participants identified continued friendships with mentees following their 'official' cessation of support. Therefore, our study supports the value of friendship peer-mentorship provides through maintained relationships.

It is evident that the participants of our study have realised the positive impact, both psychosocially and practically, that peer-mentorship contributes. However, research demonstrates that it is both mutually beneficial for the mentee and the mentor (Brusco et al., 2023; Richardson et al., 2020). As indicated in our study, the self-identified peer-mentor described the sense of fulfilment resulting from supporting and guiding others, especially when involved in the celebration of milestones and the witnessing of long-term impacts. Other researchers (Richardson et al., 2020) reported similar findings, asserting that the positive emotions shared between the peer-mentor and mentee include 'pride, purpose, usefulness, achievement, and feeling valued by others' (p. 3855). However, within the same group of participants, some peer-mentors simultaneously discussed the challenges that were a result of consistent emotional vulnerability when offering guidance, including 'uncertainty regarding the usefulness of peer support, sharing confidential information and handling emotional distress' (Richardson et al., 2020, p. 6). Further, Hutchison et al. (2024) also revealed the importance of considering 'the appropriate timing, and relatable or suitable peer selection for it to be valuable' (p. 3698). Specifically, one of their participants who

received peer support did not find it useful due to the significant age gap, differing life interests and goals, as well as the type of amputation; this participant's amputation was not circulatory, like most in his peer support group (Hutchison et al., 2024). Although these findings were not revealed in this current study, it is important to note that only one of eight participants identified as a peer-mentor, limiting the transferability of results in this role. Therefore, additional research on vulnerability fatigue, risk-management and training, and appropriate matching of peer-mentors is required.

It may also be the format through which peer support is implemented that enhances or impedes the psychosocial and practical benefits that peer-mentorship contributes. Another study (Ramstrand et al., 2024) revealed that among a group of prosthesis users, several participants utilised social media to more freely discuss daily life challenges and to access peer support when formalised programs were unavailable, or needs were unmet by treating clinicians. Peer support through an online platform may promote timely access to support services and social connections essential to a recovery journey, especially for those residing in remote locations. However, although highly accessible, receiving online support from peers without formalised training may result in challenges such as 'sharing inaccurate information, propagation of negative health behaviours, and protecting users from unwanted attention' (Ramstrand et al., 2024, p. 119). Although participants did not access peer-mentorship online in our study, similar risks may have been apparent but unknown to the mentor and mentees exchanging support, given that formalised training was not received. Further research is needed to determine if there are approaches to simultaneously bring evidence-based discussions and formalised training into peer-mentorship for individuals with lower limb amputations while still preserving the value of knowledge translation through individualised experiences (Ramstrand et al., 2024).

Lastly, this study suggests that individuals adjusting to a lower limb amputation may benefit from access to supportive services and new therapeutic relationships. Participants in our study emphasised that peer-mentorship enhanced this access through consultative guidance on health-care programs and support services that otherwise remain unknown. Previous research suggests that individuals experiencing lower limb amputation often report unfamiliarity with health-related services in their communities, and as a result, lack foundational support relevant to their recovery (Naidoo & Ennion, 2019). In addition, rural health-care shortages often result in limited availability of a multidisciplinary team, increasing the timeframes individuals must wait to



receive guidance (Naidoo & Ennion, 2019). However, participants in our study who received peer-mentorship emphasised ample support in exploring health-related resources addressing social and health needs, including financial compensation and increased connections to reputable service providers. Peer-mentorship can be considered an effective complement to help improve experiences of health navigation following lower limb amputation in small communities.

## 5 | LIMITATIONS

A sample with mostly uniform age (>53) and a single mentor was recruited. However, had the sample size been more demographically diverse, the findings would have likely been more representative of peer-mentorship perspectives and the varying needs across the lifespan. While 50% of this study's sample includes individuals who experienced lower limb amputation as a result of vascular disease, the other 50% experienced lower limb amputation as the result of a traumatic event. The trauma experienced by individuals prior to an accident could impact their adjustment to life post-amputation differently, possibly reducing the transferability of the results to those experiencing vascular amputations. It should also be noted that the peer-mentor in this research did not receive formal or specialised training to respond to the emotional, physical, or social needs of others who have experienced lower limb amputation; rather, he was altruistic in his intent and wanted to support others who have gone through a similar experience. Given the informal and non-standardised approach of this studies' peer-mentor, it should be considered a limitation of this research that the results cannot be generalised to others with a lower limb amputation who receive peer-mentorship from someone different than that of this study. Further, this study's peer-mentor did not receive socio-emotional support himself when engaging in this role, and was consenting to exposure of others' trauma. Additional research is needed on the impact of vicarious trauma to peer-mentors, and if formalised training and additional support such as being part of a union or governing body might benefit their emotional stability and longevity in the role.

Additional limitations of this study include the small communities chosen for recruitment were based on snowball sampling, likely limiting potential participants located in other smaller communities within British Columbia. Further, the primary means of telephone communication for data collection might have posed a barrier to rapport building and comfort with the interviewer, resulting in less vulnerable information shared.

## 6 | CONCLUSIONS

Participants in our study indicated that peer-mentorship satisfied an unmet need for mutual understanding and guidance, a gap in service unique to a small community population. The wisdom of lived experience was maintained through means of friendship, which enabled the improved independence of mentees, both mentally and physically. Lastly, it was found that having previous experience with various health-care providers, peer-mentorship served as an advocate, navigating conversations of care with the team, and referring to local community services. Incorporating these findings into clinical practice can enable enhanced collaborations between occupational therapists and peer-mentors to facilitate program development that works towards mutual goals, including daily living participation, psychosocial well-being, and the establishment of meaningful social connections.

## AUTHOR CONTRIBUTIONS

All authors have contributed to the study concept, design, and analysis of the data. All authors have read and approved the final manuscript.

## CONFLICT OF INTEREST STATEMENT

The authors have no conflict of interest to declare.

## DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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