

BMJ Open Synthesising evidence on the association between the structure, function and quality components of social connection and quality of life for people with dementia: a scoping review protocol

Madalena Pamela Liougas ^{1,2}, Jennifer L Campos ^{1,2,3}, Lianna Montanari,^{1,2} Jennifer S Rabin,^{2,4,5,6} Katherine S McGilton,^{1,2,7} Jennifer Bethell ^{1,2,8}

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For numbered affiliations see end of article.

Correspondence to

Ms Madalena Pamela Liougas; madalena.liougas@mail.utoronto.ca

ABSTRACT

Introduction Social connection describes how individuals connect, relate and interact with one another, and can affect quality of life (QoL) in persons with dementia. Much of the existing research on social connection does not explicitly differentiate social connection's structure, function and quality components. Due to this, social connection is described using inconsistent terminology, making it unknown how each component is associated with health and well-being outcomes. However, for people with dementia, it is unknown which components of social connection are associated with QoL and whether factors such as gender and type of dementia influence these relationships. This scoping review will identify which components of social connection have been studied in relation to the QoL for people with dementia. This will address inconsistent definitions of social connection terminology and clarify what components of social connection are described and measured in the existing literature.

Methods and analysis The six-stage scoping review framework developed by Arksey and O'Malley (2005), with updates from Levac *et al* (2010), will be used. In March 2025, a comprehensive literature search in the following databases will be conducted: MEDLINE ALL (Ovid), APA PsycInfo (Ovid), Embase Classic and Embase (Ovid), CINAHL Complete (EBSCOhost) and Scopus, from database inception. Studies will be included if they are observational studies reporting on an association between social connection and QoL in community-dwelling people with dementia. In Covidence, two reviewers will independently screen the titles and abstracts and review full-text articles based on the inclusion criteria. Data extraction will be carried out by one reviewer and cross-checked by another reviewer. A content analysis for scoping reviews will be used to analyse data and synthesise findings.

Ethics and dissemination Ethical approval is not required. Dissemination activities will include peer-reviewed publications, academic presentations and lay summaries on professional websites and social media.

STRENGTHS AND LIMITATIONS OF THIS STUDY

- ⇒ A comprehensive search strategy, developed with input from an information specialist, was applied across five databases of peer-reviewed journal articles.
- ⇒ The review follows a structured scoping methodology to ensure systematic identification and mapping of evidence.
- ⇒ People with lived experience of dementia will be consulted to contextualise the interpretation of findings.
- ⇒ Only English-language publications will be included, which may introduce language bias.
- ⇒ Grey literature will not be included, potentially limiting the scope of evidence.

INTRODUCTION

Social connection describes how individuals connect, relate and interact with one another.¹ It depends on relationships' existence, roles, qualities and the sense of connection within these relationships.² In the literature, social connection is an umbrella term encompassing several related but distinct aspects, including social network, social interaction, social engagement, social support, social isolation, social connectedness and loneliness.³ However, these aspects are inconsistently defined and measured, leading to confusion around interpreting social connection research.⁴

To reconcile inconsistencies in health research, Holt-Lunstad⁵ describes social connection according to three distinct components: structure, function and quality. The structural component describes our connection to others via the existence



of social relationships, roles and interactions.⁵ It is measured quantitatively by assessing the size or diversity of an individual's social network, lack of social network through social isolation, amount of participation through social engagement and frequency of social interactions.⁶ The functional component acknowledges our connection to others via the resources provided or available to meet our emotional, physical, tangible, informational and belonging needs.⁵ It is measured by assessing social support.⁶ The quality component comprises social connections' positive and negative affective qualities.⁵ It is measured by assessing loneliness (or social connectedness—the opposite of loneliness).⁶ Loneliness is an individual's evaluation of satisfaction with their social relations and emphasises an individual's negative emotional reaction to their dissatisfaction with the quality of their relationships.⁶ Despite the usefulness of this tripartite model, much of the existing literature on social connection does not explicitly differentiate between these components.³ As a result, it is unknown how each component is associated with health and well-being outcomes.⁷

Social connection is important to people with dementia and it affects their quality of life (QoL).^{8–11} O'Rourke *et al*⁸ conducted a systematic review of qualitative studies to determine which factors influence QoL from the perspective of people with dementia. They concluded that the experience of social connectedness or disconnectedness was central to each factor influencing QoL. Martyr *et al*¹⁰ conducted a systematic review and correlational meta-analysis to examine factors associated with QoL for people with dementia. They found that factors affecting relationships, specifically greater social engagement and better quality relationships with one's caregivers, were associated with higher QoL.¹⁰ The extent to which the different components of social connection—structure, function and quality—are associated with QoL for people with dementia remains unexplored, leading to a lack of clarity around interpreting social connection research.

Moreover, existing reviews have not disaggregated findings by gender or type of dementia,^{8 10} despite evidence suggesting that these factors may influence the relationship between different components of social connection and QoL.^{12–16} For example, women with dementia tend to experience lower social and economic privilege than men, increasing their vulnerability to social isolation and poorer QoL.¹⁷ They are also more likely to be unmarried, live alone and carry greater social burdens, all risk factors for social isolation and loneliness.¹² Paradoxically, women also report having larger social networks and more satisfying social ties than men,¹² highlighting the complexity of gendered experiences of social connection. Differences in type of dementia may also affect QoL outcomes as QoL is influenced by social connections. Research shows that individuals with Lewy body or frontotemporal dementia tend to have lower QoL than those with Alzheimer's disease.^{13–16 18 19} Additionally, individuals with vascular or mixed dementia often present with more

comorbid health conditions, which have been linked to greater loneliness and lower QoL.²⁰

Undertaking research on social connection and QoL for people with dementia is timely and essential to support the direction of targeted intervention and health policies. QoL is prioritised by health policies on dementia in Canada²¹ and worldwide.^{22–24} In 2019, Canada launched its first National Dementia Strategy, which identifies 'Prioritizing Quality of Life' as a guiding principle and emphasises the importance of 'Research and Innovation' for its successful implementation.²¹ Thus, understanding how people with dementia experience social connection may contribute to research evidence informing policies on supporting QoL.²⁵

This scoping review aims to advance understanding of the relationship between social connection and QoL in people with dementia. Social connections influence health and well-being, yet existing research uses inconsistent terminology and measurement approaches, making it difficult to interpret findings. This review will summarise the available literature to identify which components of social connection—structural, functional and quality—have been measured and examined in relation to QoL. It will also explore whether analyses account for sex and gender differences, as these factors may shape both social connection and its relationship to QoL. By mapping measures to these dimensions, the review will provide a foundation for interpreting evidence and identifying gaps that can inform future targeted interventions related to specific social connection components, thus providing more focused programme evaluation and policy development.

METHODS AND ANALYSIS

A scoping review will examine the literature on the association between social connection and QoL among people with dementia. This approach was selected following guidance from Munn *et al*,²⁶ who recommend scoping reviews when the objective is to map a concept, clarify definitions and identify gaps in the literature. Although social connection is broadly defined in the literature, its application is highly variable, with overlapping constructs (eg, social support, social network, isolation) and inconsistent measurement approaches. A scoping review is the most appropriate approach to identify measures, clarify the social connection construct and highlight conceptual and measurement gaps to inform future systematic reviews. No formal evaluation of research quality will be conducted because this scoping review aims to map the breadth of existing evidence on how components of social connection (eg, structure, function and quality) relate to QoL for people with dementia, rather than to assess the methodological rigour of individual studies.²⁶ Any amendments made to the current protocol will be documented in the final scoping review publication. This study began in March 2025 and is expected to conclude in March 2026. The scoping review protocol was not

prospectively registered. While registration of scoping reviews is increasingly encouraged, it is not a requirement.

SIX-STAGE SCOPING REVIEW APPROACH

The methods will follow the six-stage approach described by Arksey and O'Malley²⁷ and Levac *et al*²⁸: (1) identifying the research question; (2) searching for relevant studies; (3) selecting studies; (4) charting the data; (5) collating, summarising and reporting the results; and (6) consulting with people who have lived experience. The results will be reported according to the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) extension for Scoping Reviews guidelines.²⁹ This protocol has been reported using the PRISMA Protocols extension³⁰ (online supplemental appendix I).

Stage one: Identifying the research question

Through consultation with the research team, the research question was determined to be 'What components of social connection have been studied in relation to QoL for people with dementia?' Potential differences related to gender and type of dementia will also be explored.

Stage two: Searching for relevant studies

Published journal articles reporting results of observational studies will be eligible for inclusion if they report on an association between social connection (exposure) and QoL (outcome) in community-dwelling people with dementia (population). Only observational studies will be included because it is challenging to isolate social connection as a distinct exposure in intervention studies, where it may not be the primary focus or may co-occur with other constructs. Social connection may be assessed by any aspect or component.³ QoL must be assessed using a validated measure which may include these dementia-specific measures identified by Bowling *et al*,³¹ which is the most recent COnsensus-based Standards for the selection of health Measurement INstruments (COSMIN) review on QoL measures for people with dementia (online supplemental appendix II). More recent systematic reviews on QoL assessments for people with dementia have been conducted;³² however, there are no additional measures reported by these manuscripts. If studies report on participants both with and without dementia, at least two-thirds of the sample must have a diagnosis of dementia, or the results are presented for people with dementia separately. Community-dwelling is defined as not living in long-term care, other residential or institutional settings or in-patient settings.³³ If studies report on individuals living in the community and other settings, at least two-thirds of the sample must be community-dwelling, or if the results are presented separately for community-dwelling people. The eligibility criteria are restricted to community-dwelling people with dementia because measurement and interpretation of outcomes such as social connection and QoL differ between community dwelling and

more formal settings (eg, long-term care homes, hospitals, hospice). Community-dwelling individuals often rely on informal caregivers and often experience limited access to formal support services.^{34 35} This distinct context influences how outcomes such as social connection and QoL are experienced and reported (ie, usually by the person with dementia or their caregiver rather than a healthcare professional). Conference abstracts, case reports, reviews, studies without full-text availability and studies not published in English will be excluded. Only including studies published in English is consistent with streamlined methods used in scoping reviews. Although a practical requirement for this study, this limitation may introduce language bias and it will be acknowledged in the final manuscript.³⁶

In consultation with a University Health Network librarian, in March 2025, a comprehensive search strategy was developed in Ovid MEDLINE(R) (online supplemental appendix III). Terms for dementia, social connection and QoL were combined using the Boolean operator AND. The social connection search terms were adapted from a previously validated search.³⁷ The QoL search terms included the names of dementia-specific QoL measures derived from a systematic review.³¹ The search has been translated to APA PsycInfo (Ovid), Embase (Ovid), CINAHL (EBSCO) and Scopus. No date restrictions will be imposed, and searches were limited to studies published in English. In addition to database searching, reference lists of included studies will be hand-searched for additional relevant citations. Grey literature will not be included, as the scope of this review concerns studies that assessed QoL using dementia-specific measures,³¹ ensuring methodological rigour and consistency in outcome being studied. Covidence (www.covidence.org) will be used to manage the review process.

Stage three: Selecting studies

Before the study selection process, on 18 March 2025, the study team reviewed and discussed a sample of 10 retrieved citations to test the eligibility criteria. At this meeting, any questions related to the eligibility criteria were resolved to ensure consistency among reviewers. At this stage, the inter-rater agreement was not quantified. In the first phase of study selection, two reviewers will independently screen titles and abstracts to identify potentially relevant studies for inclusion. In the second phase of study selection, two reviewers will independently review full-text articles for inclusion. Any disagreements in the first or second phase of study selection will be resolved through or by discussion with a third reviewer.

Stage four: Charting the Data

Data that will be extracted from the included studies is outlined in the data extraction form in online supplemental appendix IV. In this form, if the study results are stratified by gender and type of dementia, these variables will be extracted accordingly. This data extraction form will be updated and revised as necessary. Before data extraction, this form will be pilot-tested on a random sample of five studies. Following a successful pilot test, the remaining studies will have their



data extracted independently by one researcher. Another researcher will cross-check the extraction of each study for consistency.³⁶ Regular discussions will occur throughout this process; any disagreements will be resolved by discussion with a third reviewer.

Stage five: Collating, summarising and reporting results

Results will be presented according to (1) study characteristics summarised with frequency and percentage statistics and (2) a content analysis for scoping reviews.^{38 39} The content analysis will consist of three phases: preparation, organisation and reporting. In the *preparation phase*, measures used to assess social connection will be identified and their items extracted. Any studies that stratify their results by participants' gender and type of dementia will be noted. Next, in the *organisation phase*, the identified measures and their items will be compared with Holt-Lunstad's⁵ definitions of social connection structure, function and quality components. Each measure's items will be organised according to one or more definitions. Additionally, it will be explored whether the components of social connection assessed differ based on participants' gender and type of dementia. The preparation and organisation phases will be iterative. Progress and results will be shared regularly with fellow reviewers, who will be given the opportunity to provide feedback and suggestions. Third, in the *reporting phase*, a chart will be created to depict which measures and items have been used to assess social connection's structure, function and quality components. The chart will indicate any findings specific to gender and type of dementia. This will involve summarising which social connection components have been reported separately for different genders and types of dementia. Additionally, a list of QoL assessment measures and their items will be compiled to illustrate the range of measures used to evaluate this construct in relation to social connection.

Stage 6: Consulting with people who have lived experience (Patient and public involvement)

People with lived experience will consist of members of the Engagement of People with Lived Experience of Dementia (EPLD) group (www.epled.ca), part of the Canadian Consortium on Neurodegeneration in Aging.^{40 41} All EPLD Advisory Group members have experience of dementia—either as persons living with dementia or current and former care partners—and all have experience of dementia outside of residential and hospital settings.⁴¹ EPLD Advisory Group members are recruited from across Canada to provide diverse perspectives and come from various professional and cultural backgrounds. For this review, Patient and Public Involvement is formalised through EPLD's role in contextualising research findings during stage five. Specifically, EPLD members will be consulted during data analysis to support the interpretation of study findings.^{42 43} One or more virtual (via Zoom) meetings will be held to present preliminary findings, during which members will be invited to provide feedback, comment and critique the results.

The study was informed by the research priorities of people with lived experience of dementia, particularly the priority

of supporting the emotional well-being of persons with dementia.⁴⁴ The EPLD Advisory Group was not involved in earlier stages (ie, determining study design) due to time constraints aligned with internal institutional timelines. The findings of this work will be discussed in the presentation of study results and, specifically, in regard to study limitations.

ETHICS AND DISSEMINATION

As scoping reviews use publicly available data, ethical approval is not required. Dissemination activities will include peer-reviewed publications, academic presentations at local, national and international conferences and short summaries in lay language on professional websites and social media.

Author affiliations

¹KITE Research Institute Toronto Rehabilitation Institute, University Health Network, Toronto, Ontario, Canada

²Rehabilitation Science Institute, University of Toronto - St. George Campus, Toronto, Ontario, Canada

³Department of Psychology, University of Toronto - St. George Campus, Toronto, Ontario, Canada

⁴Dr. Sandra Black Centre for Brain Resilience and Recovery, Hurvitz Brain Sciences Program, Sunnybrook Research Institute, Toronto, Ontario, Canada

⁵Department of Medicine (Neurology), Sunnybrook Health Sciences Centre, Toronto, Ontario, Canada

⁶Harquail Centre for Neuromodulation, Hurvitz Brain Sciences Program, Sunnybrook Research Institute, Toronto, Ontario, Canada

⁷Lawrence S. Bloomberg Faculty of Nursing, University of Toronto - St. George Campus, Toronto, Ontario, Canada

⁸Institute of Health Policy, Management and Evaluation, University of Toronto - St. George Campus, Toronto, Ontario, Canada

Contributors MPL conceived the idea, developed the research question and study methods, drafted the manuscript and approved the final manuscript. JSR, LM, JLC, KSM and JB contributed to developing the research question and refining the study methods, provided feedback and approved the final manuscript. MPL is the guarantor of the review.

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ORCID iDs

Madalena Pamela Liougas <https://orcid.org/0000-0002-2060-7323>

Jennifer L Campos <https://orcid.org/0000-0002-7054-3946>

Jennifer Bethell <https://orcid.org/0000-0002-6141-9011>

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