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The Older Adult–Primary Informal Caregiver Dyad: Toward a Dyad-Centred Framework for Geriatric Care

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ABSTRACT

The Person-centred care is a cornerstone of modern geriatric medicine and underpins the World Health Organization's Healthy Ageing framework, the Integrated Care for Older People (ICOPE) approach, and comprehensive geriatric assessment. However, the successful implementation of these models frequently depends on the active participation of a primary informal caregiver, whose health, functional capacity, and psychosocial wellbeing directly influence the effectiveness of care delivered to older adults. Although the caregiving dyad has been recognised in the literature as an analytical perspective for investigating caregiver–recipient interactions, it has not been adopted as an organising framework for geriatric care. In this opinion article, we argue that the person-centred care should be extended—not replaced—through a dyad-centred framework in which the older adult–primary informal caregiver dyad becomes the fundamental unit for assessment, intervention, and integrated care whenever a primary informal caregiver plays a central role in supporting older people.

We discuss how this conceptual shift aligns with the principles of healthy ageing by recognising the interdependence of functional ability, intrinsic capacity, frailty, independence, autonomy, and psychosocial wellbeing within the dyad. We further propose that systematic assessment of caregiver health, including frailty and functional status, should become an integral component of comprehensive geriatric assessment and integrated primary care. Adopting a dyad-centred framework has the potential to strengthen clinical decision-making, improve integrated care, and promote healthy ageing by addressing the needs of both older adults and the individuals who sustain their care.

Keywords: Person-Centred Care; Dyad-Centred Care; Informal Caregiver; Older Adults; Comprehensive Geriatric Assessment; Frailty; Functional Ability; Integrated Care; Healthy Ageing

Introduction

Population ageing has profoundly transformed the priorities of healthcare systems worldwide [1]. Beyond increasing longevity, the principal challenge for geriatric medicine is to preserve functional ability, independence, and autonomy throughout the ageing process [2]. In response to this challenge, the person-centred care has become one of the defining principles of modern geriatrics and underpins the World Health Organization (WHO) framework for Healthy Ageing and the Integrated Care for Older People (ICOPE) approach [3-4]. Through the comprehensive geriatric assessment (CGA), these models have shifted clinical practice from a disease-oriented paradigm towards one focused on intrinsic capacity, functional ability, individual preferences, and personalised care planning. The successful implementation of person-centred care [3-4], however, rarely depends on the older adult alone. In community settings, the effectiveness of prevention, treatment, rehabilitation, and long-term care frequently relies on the active participation of a primary informal caregiver, who assumes responsibility for supporting daily activities, implementing care plans, monitoring health status, coordinating healthcare services, and promoting adherence to therapeutic interventions [5-7].

In many cases, the caregiver becomes an indispensable partner in maintaining functional ability, delaying dependency, preventing or reversing frailty, and enabling older adults to remain in their own homes [6,8-11]. Despite this essential role, contemporary geriatric care continues to focus predominantly on the older people as the principal recipient of assessment and intervention [2-4]. Although caregivers are increasingly recognised as key partners in care [5-11], they are generally considered contextual or supportive elements surrounding the patient rather than individuals whose own health, functional capacity, psychological wellbeing, and social circumstances may directly determine the success of geriatric interventions. Consequently, the health of the older adult is frequently assessed independently of the health of the person who makes much of that care possible [12].

Although the concept of the caregiving dyad is well established in the literature [13-16], it has been used predominantly as an analytical framework to investigate specific research questions [14-16]. Pristavec demonstrated that caregiver burden and perceived caregiving benefits influence subsequent depression and anxiety among older care recipients, illustrating the value of the dyad as a unit of analysis for understanding caregiving outcomes, and as an analytical framework to examine the reciprocal relationships between caregivers and care recipients [16]. However, the dyadic perspective has not yet been adopted as a conceptual framework to guide comprehensive geriatric assessment, clinical decision-making, and integrated care, nor has it become one of the organising paradigms of geriatric medicine. Against this background, extending comprehensive geriatric care to include the primary informal caregiver becomes a clinical priority and a fundamental component of integrated care.

Rather than considering the caregiver solely as a facilitator of care, this perspective recognises that the caregiver's health, functional capacity, psychological wellbeing, and social circumstances directly influence the effectiveness of interventions delivered to the older adult. The focus of care should therefore expand from the individual to the older adult–primary informal caregiver dyad. Although integrated geriatric care should remain centred on the older person, it should also encompass the older adult–primary informal caregiver dyad whenever a primary informal caregiver plays an essential role in care, recognising that preserving functional ability, intrinsic capacity, independence, and autonomy depends on the health, resilience, and functional capacity of both members of the dyad. Therefore, we propose extending the principles of person-centred care towards a dyad-centred framework for geriatric care. Under this framework, the older adult–primary informal caregiver dyad becomes the fundamental unit for assessment, intervention, and integrated care.

This approach acknowledges that preserving functional ability, intrinsic capacity, independence, autonomy, and healthy ageing requires the systematic assessment and support of both members of the dyad, particularly when the caregiver is also an older adult or is experiencing declines in physical, cognitive, or emotional capacity. Under these circumstances, the health and functional trajectories of the older adult and the caregiver become intrinsically interdependent. We therefore argue that the older adult–primary informal caregiver dyad should be recognised not only as a unit of analysis for research, but also as a dyad-centred framework for geriatric medicine. Such a framework extends the principles of person-centred care by recognising that preserving functional ability, intrinsic capacity, independence, autonomy, and healthy ageing often depends on assessing and supporting both members of the dyad simultaneously.

This conceptual shift is particularly relevant because many primary informal caregivers are themselves older adults or individuals already experiencing declines in physical, cognitive, or emotional capacity [6,8,17-19]. Their frailty, multimorbidity, or reduced functional reserve may compromise not only their own health but also the effectiveness of interventions delivered to the older adult. We therefore propose that, whenever a primary informal caregiver plays a central role in care, geriatric medicine (geriatrics and gerontologics) should evolve from a person-centred approach towards a dyad-centred approach, in which the older adult and the primary informal caregiver constitute the fundamental unit for assessment, intervention, and integrated care.

The Need to Extend Person-Centred Care

The person-centred care has transformed geriatric medicine by placing the older adult at the centre of healthcare decisions [3-4,12]. This approach has improved the assessment of intrinsic capacity, functional ability, frailty, independence, and autonomy through

comprehensive geriatric assessment and integrated care models [3-4,12]. However, in routine clinical practice the implementation of these interventions frequently depends on the active participation of a primary informal caregiver. Although caregivers are increasingly recognised as essential partners in care [5-11,13-19], they are rarely considered recipients of systematic assessment or intervention [20]. Their role is commonly viewed as supportive rather than constitutive of the care process. As a result, geriatric care often assumes that the caregiver has the physical, cognitive, emotional, and social capacity to implement recommendations without evaluating whether this assumption is valid.

This disconnect creates an important gap between the theoretical principles of person-centred care and the realities of community-based geriatric care. The health of the older adult is assessed comprehensively, whereas the health of the individual upon whom many interventions depend frequently remains unknown.

Why the Current Paradigm is No Longer Sufficient

The increasing complexity of ageing has altered the organisation of long-term care [21]. Population ageing, multimorbidity, frailty, and functional dependence have progressively transferred many aspects of care from healthcare institutions to households [21-23], where primary informal caregivers assume responsibility for implementing recommendations generated through comprehensive geriatric assessment.

Consequently, the success of interventions intended to preserve functional ability or prevent disability depends not only on the older person's intrinsic capacity but also on the caregiver's ability to sustain care over time. Physical limitations, psychological distress, cognitive decline, social isolation, caregiver burden, or frailty in the caregiver may compromise adherence to interventions, delay functional recovery, and reduce the effectiveness of integrated care [6,24].

This situation is particularly relevant because many primary informal caregivers are themselves older adults or individuals experiencing age-related declines in health and function. Nevertheless, caregiver frailty, functional capacity, and intrinsic capacity remain poorly characterised within geriatric care models despite their potential influence on clinical outcomes.

Toward a Dyad-Centred Framework for Geriatric Care

The dyadic perspective has previously been used as an analytical approach to investigate reciprocal relationships between caregivers and care recipients [13-16]. Studies adopting this perspective have demonstrated that caregiver characteristics influence patient outcomes and vice versa. However, these applications have largely remained methodological, providing analytical frameworks for individual research questions rather than guiding the organisation of geriatric care. We propose an extending person-centred care through a dyad-centred framework in which the older adult–primary informal caregiver dyad becomes the fundamental unit for assessment, intervention, and integrated care whenever a primary informal caregiver plays an essential role in supporting the older person. This proposal does not replace person-centred care. It extends its principles by recognising that functional ability, intrinsic capacity, frailty, psychological wellbeing, and social circumstances are dynamically shared within the caregiving relationship. Consequently, assessment should no longer focus exclusively on the older adult but also on the caregiver whose health directly influences the achievement of therapeutic goals.

Functional Interdependence: The Theoretical Basis of Dyad-Centred Geriatric Care

The proposed dyad-centred framework is founded on the concept of functional interdependence, whereby the health trajectories of the older adult and the primary informal caregiver become reciprocally linked through the continuous provision of care [25-26]. Rather than functioning as two independent individuals, both members of the dyad influence each other's capacity to achieve and maintain optimal health outcomes. Moreover, the concept of dyadic interdependence is already supported by a growing body of evidence [26]. However, its application has remained largely confined to understanding reciprocal influences between caregivers and care recipients. We argue that the implications of this evidence extend beyond dyadic research and justify the adoption of a dyad-centred framework for geriatric care. Evidence for dyadic interdependence and functional interdependence now warrants a transition from dyadic research to dyad-centred geriatric care [25-28].

Functional interdependence extends beyond the traditional understanding of caregiving as the provision of assistance with daily activities [28-30]. It recognises that the caregiver's physical health, cognitive function, emotional wellbeing, resilience, social support, and functional capacity directly determine the feasibility and effectiveness of interventions aimed at preserving the older adult's intrinsic capacity, functional ability, independence, and autonomy [25-31]. Likewise, progressive disability, frailty, or cognitive decline in the older adult may substantially increase caregiving demands, thereby accelerating physical exhaustion, psychological distress, social isolation, or functional decline in the caregiver [30-31]. Consequently, the health trajectories of both individuals become dynamically interconnected [25-28]. This reciprocal relationship is particularly evident in geriatric medicine, where many interventions require sustained participation beyond the clinical encounter [7,32-33].

Exercise programmes, nutritional interventions, medication management, fall prevention strategies, rehabilitation, and comprehensive care plans also frequently depend on the caregiver's capacity to supervise, reinforce, and maintain therapeutic recommendations within the home environment. The effectiveness of these interventions is therefore determined not solely by the older adult's clinical condition but also by the caregiver's ability to implement them consistently

over time. The concept of functional interdependence becomes even more relevant when the primary informal caregiver is also an older adult. In these circumstances, both members of the dyad may simultaneously experience multimorbidity, frailty, reduced intrinsic capacity, or declining physical and cognitive function. Therefore, under such conditions, deterioration in one individual may directly compromise the health and functional recovery of the other, creating a reciprocal cycle of vulnerability that cannot be adequately understood by evaluating either person in isolation.

Importantly, functional interdependence is not restricted to older caregivers. Middle-aged caregivers frequently experience chronic disease, psychological distress, musculoskeletal disorders, sleep disturbances, occupational burden, and reduced social participation associated with prolonged caregiving responsibilities. These conditions may similarly affect their ability to provide sustained, high-quality care and, consequently, influence the health outcomes of the older adult. Functional interdependence should therefore be understood as a dynamic characteristic of the caregiving relationship rather than as a phenomenon determined solely by chronological age. Recognising functional interdependence has important implications for geriatric medicine. It suggests that comprehensive geriatric assessment should no longer evaluate only the older adult's vulnerabilities but should also identify vulnerabilities affecting the caregiver that may compromise the achievement of therapeutic goals.

Within this perspective, caregiver frailty, functional limitations, psychological wellbeing, and social resources become clinically relevant because they directly influence the success of interventions directed at the older adult. Functional interdependence therefore provides the theoretical justification for extending person-centred care towards a dyad-centred framework. The rationale for assessing the older adult–primary informal caregiver dyad does not arise simply because two individuals are involved in care, but because their health, functional capacity, and wellbeing become sufficiently interconnected that they constitute a single clinical unit for assessment, intervention, and integrated care.

Implications for Geriatric Medicine

Adopting a dyad-centred framework has implications that extend beyond conceptual discussions. Comprehensive geriatric assessment should systematically include evaluation of caregiver health, functional capacity, frailty, caregiver burden, psychological wellbeing, and available social support whenever the caregiver is integral to care delivery [3-4,12,33-36]. Such an approach would permit earlier identification of vulnerable dyads, facilitate targeted interventions, and strengthen integrated care planning [25-28]. From a research perspective, recognising the older adult–primary informal caregiver dyad as the fundamental unit of assessment, would promote longitudinal studies examining reciprocal health trajectories, the prevalence and determinants of caregiver frailty, and interventions directed at both members of the dyad rather than the older adult alone.

Ultimately, extending person-centred care towards a dyad-centred framework acknowledges that successful ageing is frequently achieved not by one individual but through the interaction of interdependent individuals. Thus, preserving the health, functional ability, and resilience of both members of the dyad may therefore represent the next evolution of integrated geriatric care.

Future Directions for Research and Clinical Practice

The proposed dyad-centred framework opens several opportunities for advancing geriatric medicine beyond its current boundaries [37-40]. Future research should focus on validating the clinical utility of dyad-based assessment by determining whether the systematic evaluation of both members of the caregiving relationship improves functional outcomes, quality of life, healthcare utilisation, and long-term care planning [37-40]. Prospective cohort studies and pragmatic clinical trials will be essential to establish the effectiveness of interventions designed for both members of the dyad rather than for the older adult alone. An equally important priority is the development and validation of assessment instruments capable of characterising the caregiving dyad as a whole. Current geriatric assessment tools evaluate older adults comprehensively, while caregiver assessments are generally limited to burden or psychological distress.

Future instruments should incorporate multidimensional domains that capture the interaction between both individuals, including physical function, cognitive status, emotional wellbeing, social resources, caregiving capacity, and resilience. The adoption of a dyad-centred framework also has important implications for healthcare delivery. Clinical pathways should facilitate interdisciplinary interventions that address the needs of both individuals, integrating medical, nursing, rehabilitation, psychological, and social care within a coordinated model. Likewise, healthcare professionals should receive training that enables them to recognise situations in which caregiver-related factors may influence clinical decision-making and therapeutic outcomes. Moreover, recognising the caregiving dyad may support the design of policies that acknowledge primary informal caregivers as active participants in care rather than solely as providers of assistance.

This perspective could inform resource allocation, caregiver support programmes, preventive strategies, and community-based services aimed at maintaining care capacity throughout the ageing process. Finally, extending geriatric care towards a dyad-centred framework provides an opportunity to redefine how successful ageing is supported in clinical practice. A future research should determine how this approach can be incorporated into comprehensive geriatric assessment, integrated care pathways, and public health strategies, with the ultimate goal of promoting sustainable, person-oriented care that recognises the shared contribution of older adults and their primary informal caregivers to preserving functional ability and sustaining healthy ageing over time.

The dyadic perspective is well established in the literature and has been applied across multiple chronic conditions to understand reciprocal relationships between care recipients and informal caregivers. Existing work has advanced dyadic health science, dyadic illness management, and dyadic interventions. Building on this body of evidence, we propose extending these concepts beyond research methodologies and disease-specific interventions towards a dyad-centred framework for geriatric care.

Conclusion

In conclusion, the evidence accumulated over the past two decades has progressively advanced from caregiver research to dyadic health science and dyadic interventions rather than replacing person-centred care, the next logical step is to translate this evidence into clinical practice by adopting a dyad-centred model of geriatric care (older adult–primary informal caregiver dyad), as the appropriate unit for assessment, intervention, and integrated care, whenever a primary informal caregiver is integral to the care of an older adult.

Competing Interests

Authors have declared that no competing interests exist.

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