

CAN A GENERATED CAREGIVER REPAIR ATTACHMENT?

Implementing Ideal Nurture In Australian Stepped Care

A sociotechnical analysis, written from an independent University-researcher perspective.



Technological Innovation and Digital Health

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3,934 words

THE INNOVATION

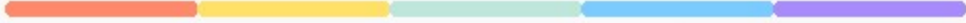
WHAT IS BEING PROPOSED

Daniel P. Brown's Ideal Parent Figure protocol for adult attachment repair, externalised from clinician-guided imagery into augmented and virtual reality, and delivered by an artificial-intelligence-generated caregiver avatar, under clinical governance.

Scenes authored per patient from four to five clinician-led intake sessions and the clinical record.

The workforce model is task-shifting. A scarce, expensive clinician leads intake, approves all content, and conducts preparation and integration. A lower-cost professional supervises the repetitive immersive sessions.

THE MISSING MIDDLE



Several hundred thousand Australian adults whose needs are too complex for the brief, capped sessions of Better Access, yet not acute enough for state specialist services. Compounded by the uneven distribution of clinicians, which leaves rural and remote communities chronically underserved, and by cost, since use is lowest among those with the greatest need.

A real and well-documented need.

Productivity Commission (2020); Pirkis et al. (2022)

THE CASE FOR IT IS REAL

THEORY

Coherent and clinically detailed.
Strengthening felt attachment security improves mental health, and that broader principle has robust support.

EVIDENCE

One independent, peer-reviewed pilot reports significant reductions in symptoms and attachment-related distress in adults with complex PTSD.

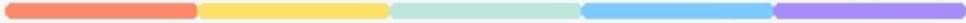
ACCESS

Roughly one per cent of people cannot voluntarily generate mental imagery. For them, and for those with no safe figure to imagine, an external scene may reach where imagery work cannot.

Brown & Elliott (2016); Parra et al. (2017); Mikulincer & Shaver (2016); Dance et al. (2022)

THEN STRESS-TEST

THE EVIDENCE IS SMALL AND IT IS UNCONTROLLED



No randomised controlled trial against an active comparator. The developer's signature case series, in which twelve patients reportedly all reached earned-secure attachment, was scored largely by the senior author over a mean of about 3.4 years of therapy. Its implausibly large reported effect bears the signature of a single unblinded rater rather than a clean result. The two existing studies do not even share an outcome instrument.

The mechanism the evidence supports is slow, relational and therapist-mediated.

Which is precisely the element the platform proposes to automate.

THE SETTING

COORDINARE. A HYPOTHETICAL CASE

The South Eastern New South Wales Primary Health Network commissions services from metropolitan Wollongong and the Illawarra to rural and remote southern New South Wales. A single network therefore spans both metropolitan access and rural maldistribution, which allows the equity questions to be examined in one setting.

A hypothetical implementation case chosen for the analysis. Not an engagement, partnership or commissioned work.

Ideal Nurture is modelled as a clinically governed adjunct commissioned into existing stepped care, never a substitute.

THE OUTCOME IS DECIDED AT THE EDGES

SOLID EDGES

Established flows: oversight, data, funding, regulation. The clinician, the network, the provider, the regulator, the referrers, the headset, the record.

DASHED EDGES

Genuine uncertainty: whether the relational mechanism survives pre-rendering, whether the design fosters dependence, whether the data layer can be reconciled with Indigenous data sovereignty, whether a service with no reimbursement line can be sustained.

Read through the social shaping of technology, Ideal Nurture is not an autonomous curing machine but a sociotechnical assemblage whose effect is constituted in use. The determinist reading cannot explain why the same protocol might repair one person and foster dependence in another.

CHALLENGE ONE

THE AUTOMATION OF CONTINGENCY

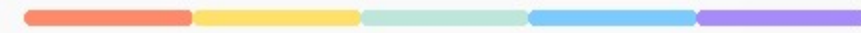


Does the active ingredient survive externalisation?

NASSS domains: the condition, the technology.

CHALLENGE ONE

CONTENT. TECHNIQUE. CONTINGENCY.



Content

The scene itself. Reproduced faithfully, and authored from deep intake and the patient's own history.

Technique

Pacing, gravity, timing. Partly portable. Brown himself abandoned formal hypnotic ritual once a simple instruction sufficed.

Contingency

Moment-to-moment responsiveness, and the clinical judgement of what to do with what arises. Neither content nor technique.

The evidence locates the cure in the third. A caregiver who matches affect as it arises, in a reciprocal loop measured in seconds.

Ablon et al. (1993); Brown & Elliott (2016), whose method neither offers nor condones preestablished scripts.

CHALLENGE ONE

THE RESIDUAL DILEMMA

EITHER

the corrective experience occurs inside the non-contingent core, in which case the loss of contingency bites, and it is supervised by a non-expert who cannot repair a mis-attuned moment as it happens.

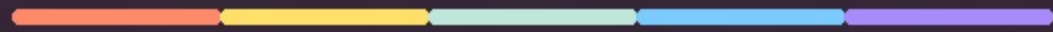
OR

the real repair lives in the human preparation and integration, in which case the avatar is an expensive scaffold around what remains human-delivered therapy.

No study isolates externalised against in-session co-created imagery on a measure of internal working models. The question is genuinely open rather than settled either way. Immersive technology adds reach and vividness, not a new mechanism.

CHALLENGE TWO

MANUFACTURING DEPENDENCE



The equity challenge.

NASSS domains: the technology, the adopter system, the wider system.

CHALLENGE TWO

THE SAME MECHANISM THAT COMFORTS

The comfort is real

Empathetic conversational agents can reduce loneliness, chiefly by making people feel heard. De Freitas et al. (2025)

And the harm rides it

Heavier use predicted higher loneliness, less real-world socialisation and greater emotional dependence, with usage duration the strongest predictor. Fang et al. (2025); Zhang et al. (2025); Laestadius et al. (2024)

The platform optimises for frequent, affective, sustained sessions: the exact pattern most associated with harm. Engagement as a measure of success may be harm by design, and a pre-rendered avatar cannot read or de-escalate a distressed user in the moment.

CHALLENGE TWO

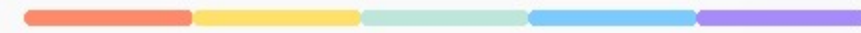
THE EQUITY INVERSION

The access pitch and the harm signal point at the same people. Those with least access to a human alternative are offered the synthetic substitute, whose documented risks fall hardest on the lonely and the isolated, including rural residents and those priced out of capped care.

Lupton (2014) names the deeper move: responsibility for care shifts onto the individual, while the relational labour, and the data, accrue to a product.

CHALLENGE TWO

WHOSE DATA. AND WHOSE CONSTRUCT?



The personalisation that strengthens the first challenge is built by ingesting the patient's whole clinical record into a bespoke model: a large surface for privacy and consent, and an acute matter of Indigenous data sovereignty, the right of Aboriginal and Torres Strait Islander peoples to govern data about their communities.

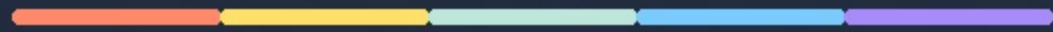
A more fundamental problem must be named with care, and with the honest caveat that this analysis has not done the cultural research it would require. Attachment theory's dyadic, Western frame is, in a peer-reviewed view, not valid for Indigenous peoples, whose child-rearing is communal and distributed across many kin, so that security spread across several carers can be misread as disordered.

A singular ideal parent figure may be the wrong construct. Any engagement would have to run through ACCHOs on their own terms.

Choate & Tortorelli (2022); Wright et al. (2024)

CHALLENGE THREE

CLEARANCE IS NOT VIABILITY



Adoption, scale-up and sustainability.

NASSS domains: the value proposition, the organisation, the wider system, embedding over time.

CHALLENGE THREE

CLEARANCE IS A FLOOR. NOT VIABILITY

The first company to gain United States clearance for a prescription digital therapeutic entered bankruptcy in 2023 despite that clearance, for want of reimbursement. In Australia, software that treats a mental-health condition is a medical device, so the avatar would require entry on the Australian Register of Therapeutic Goods. There is no Medicare Benefits Schedule line for a product of this kind.

Pear Therapeutics (2023); Greenhalgh et al. (2017)

Which leaves it dependent on fragile Primary Health Network grants. Programmes marked by complexity across several NASSS domains rarely, if ever, become mainstreamed.

CHALLENGE THREE

TRAIN ONCE. REACH MILLIONS.



Cost is concentrated in training the bespoke model, with near-zero marginal cost on software and headsets, underwriting a promise to train once and reach vast new markets at the click of a button. This is the strongest anti-deterministic case in the analysis.

Solutionism

The assumption that spread is frictionless.
Morozov (2013)

Performative Expectation

The vast-market figure doing investment work in the present, ahead of any evidence.
Borup et al. (2006)

Work As Done

Not work as imagined. The per-patient clinical labour does not scale to zero. Berg (2001)

Every market brings its own regulator, reimbursement and trained clinicians. Localisation is not translation.

THE TRILEMMA

These challenges do not form a list. They interlock, so that the platform's best defence on one front worsens another.

The contextual fidelity that strengthens the first challenge is exactly what maximises the bonding and dependence of the second, and enlarges its data surface. The engagement that would prove the business case of the third is the strongest predictor of harm in the second.

No single position answers all three at once.

SPECIFY AND TEST BEFORE CLAIMING



Success is plural

Duration is viability for the developer and the marker of harm for the user. Design against engagement-maximisation, with session limits and planned tapering.



Claims are gated

Pre-registered, falsifiable tests, mechanism first. Dependence, displacement and crisis-handling as primary safety endpoints, not afterthoughts.



Contingency is placed empirically

Test the floor of clinician contingency at the preparation and integration bookends, and the minimum professional mix that keeps the work safe.



The organisation adapts, not only the tool

Therapist oversight as non-negotiable governance. Blinded, independent outcome measurement. Data governance through community-controlled bodies.



A staged, co-designed pilot

One site, a defined cohort, explicit stopping rules, lived experience led from design rather than added at evaluation.

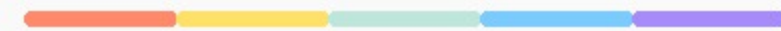
THE EFFECT IS NOT A PROPERTY OF THE AVATAR

It is produced, or lost, in the contingent relational and organisational world the technology enters. The three challenges are one but viewed from three sides. Whether the active ingredient survives externalisation is unestablished, not refuted. Whether the design manufactures dependence concentrated on the underserved is well evidenced. Whether the service can be adopted, scaled and sustained is adverse on present evidence.

The strategy does not promise success. It specifies what would have to be true, and tested, before the claim could honestly be made.

The map is a boundary choice. NASSS may under-weight the relational mechanism at the centre of this case. Three challenges is itself a simplification. For a genuinely complex programme, a disciplined account of uncertainty is the responsible conclusion rather than a verdict.

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Full reference list in the report.