

PRAXIS

WHERE REFLECTION &
PRACTICE MEET



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P R A X I S

Where Reflection & Practice Meet

Volume 21 (2025)

Archiving as Resistance: Disseminating Knowledge in Times of Repression

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Archiving as Resistance: Disseminating Knowledge in Times of Repression

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Mission Statement

The School of Social Work at Loyola University Chicago created Praxis: Where Reflection & Practice Meet to provide a platform for the scholarly work of students and alumni. Our mission is to encourage and support the development of social work knowledge that will enhance the lives of the clients we serve, embody the humanistic values of our profession, and promote social justice and care for vulnerable populations. Praxis respects and welcomes all viewpoints.

Editorial Policy

Praxis is published by students in the School of Social Work at Loyola University Chicago. The editorial board is composed of masters and doctoral social work students and alumni. The board encourages students and alumni of the School of Social Work to submit papers that provide insight into clinical, policy, research, education and other areas relevant to social work practice. Submissions are accepted throughout the year. Articles should be no longer than 20 double-spaced pages and submitted as a Microsoft Word document file (.doc or .docx). All identifying information, including contact information, should be on a separate page. Responsibility for accuracy of information contained in written submissions rests solely with the authors. Opinions expressed in the journal are those of the authors and do not necessarily reflect the views of the School of Social Work or the Editorial Board.

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Land Acknowledgement for Loyola University Chicago

The Loyola University Chicago community acknowledges its location on the ancestral homelands of the Council of the Three Fires (the Ojibwa, Ottawa, and Potawatomi tribes) and a place of trade with other tribes, including the Ho-Chunk, Miami, Menominee, Sauk, and Meskwaki. We recognize that descendants of these and other North American tribes continue to live and work on this land with us. We recognize the tragic legacy of colonization, genocide, and oppression that still impacts Native American lives today. As a Jesuit university, we affirm our commitment to issues of social responsibility and justice. We further recognize our responsibility to understand, teach, and respect the past and present realities of local Native Americans and their continued connection to this land.

Written by the Land Acknowledgement Committee who were guided by Dr. Michael Schuck, professor in theology and the School of Environmental Sustainability (SES) and co-director of the Jesuit Ecology Project, and Dr. Nancy Tuchman, founding dean of SES.

Labor Acknowledgement

We recognize that the United States as we know it was built at the often-fatal expense of forcefully enslaved Black people. We must acknowledge that much of what we know of this country today, including its culture, economic growth, and development has been made possible by the labor of enslaved Africans and their descendants who suffered the horror of the transatlantic trafficking, chattel slavery, and, later on, dehumanization through segregation and Jim Crow laws.

We acknowledge and remember those who did not survive the Middle Passage, those who were beaten and lynched at the hands of White Americans, and those who are still suffering while fighting for their freedom. We remember those who toiled the ground where many theatres have been built and resurrected.

We are indebted to their labor and their unwilling sacrifice, and we must acknowledge the tremors of that violence throughout the generations, and the resulting impact and generational trauma is still felt and witnessed today.

Labor Acknowledgement from Paramount Theatre, Aurora IL. Thank you to R. Christopher Maxwell and the Black Theatre Caucus, as well as all the authors of the We See You, W.A.T. Demands, and Dr. TJ Stewart from Iowa State University for providing the framework for this language.

Editorial

Archiving as Resistance: Disseminating Knowledge in Times of Repression

It has been five years since the last volume of *Praxis* was published. In those five years, a global pandemic, genocides, and climate disasters escalated. Simultaneously, a new era of academic repression was born. In recent months, funding for research on LGBTQ+ healthcare, abortion access, and support for migrants in the United States has been slashed. In this era of rising academic repression, surveillance, and social fragmentation, there is no better time than now to reintroduce *Praxis*.

Academic journals like *Praxis* provide a stable, citable archive. Once published, this archive is harder to suppress, distort, or erase. Journals preserve the intellectual output of universities and colleges. Amidst outside censorship attempts, academic journals maintain ethical commitments to academic integrity and freedoms. *Praxis* is a vehicle for the academic insights of social workers and social work students, who are on the front lines of liberatory work alongside communities currently being targeted for erasure. Preserving these insights in writing directly combats that erasure.

Social work, when grounded in our commitment to justice and collective well-being, must reclaim and protect spaces for radical imagination--

speaking truth to power, and building solidarities across differences. The word praxis is a reminder that knowledge alone is not the end goal, but rather a means of liberation by affirming theory is inextricably linked to action. In both scholarship and practice, social workers must remain accountable not only to the profession but also to our communities whose lives and struggles demand we act.

Social work is not a discipline that can afford disconnection from the communities it purports to serve. It is our hope that as *Praxis* is reestablished, it will continue to be a platform where students, alums, future educators, and practitioners stand up in this critical moment and document their work. Now more than ever, our theory must become action.

This volume and the re-ignition of *Praxis* were only possible thanks to the commitment and work of the Editorial Board and our faculty advisors Dr. Nathan Perkins, PhD, MSW, MS and Dr. Abha Rai, PhD, MSW.

Casey Callahan, JD, MSW
Rachel Young, MSW

Policy Proposal: Nurse Midwifery Program Expansion Initiative to Address Racial Disparities in Maternal and Perinatal Health

Lauren Drury

The healthcare system in the United States fails to provide equitable maternal care for Black women, which is reflective of the entrenched racial inequalities that continue to drive disproportionately high maternal mortality, severe maternal morbidity (SMM), and pregnancy complications. Often, these complications are misattributed to their behavior, which overlooks the embedded structural racism, thus minimizing barriers to healthcare access, treating disparities as isolated issues, and neglecting the importance of cultural competency in healthcare. The paper will challenge these misconceptions by acknowledging the maternal health crisis as a chronic social problem—a widespread, disruptive issue that requires systemic and community-driven solutions (Brueggemann, 1996)—and implementing a non-ideal theoretical framework and a bottom-up perspective. This approach rejects traditional medical models, favoring a sociological framework grounded in community trust and culturally responsive practice. The paper examines how micro-, mezzo-, and macro-level institutions contribute

to the Black maternal health crisis. The essential role of social workers in addressing these disparities through advocacy, systemic reform, and community engagement will be emphasized. It will call for the integration of midwifery into the maternal healthcare system by drawing on national and global evidence of its effectiveness in reducing maternal health inequities. The paper concludes with a policy proposal—the Nurse Midwifery Program Expansion Initiative—which addresses systemic shortcomings by incentivizing nursing schools to develop midwifery programs tailored to underserved populations, supported by federal funding and collaboration with the Health Resources and Services Administration (HRSA).

Macro-Systemic Harm in Black Maternal Health

Macro-systems refer to large-scale policies, laws, and societal structures that shape the population-level outcomes. In the United States, it is evident that these systems have consistently failed to serve as a protective factor for Black maternal healthcare and have led to disproportionately poor health outcomes due to

deeply embedded structural racism. In 2021, the maternal mortality rate for non-Hispanic Black women was 69.9 per 100,000 live births—nearly three times that of white women—and 84% of these deaths were preventable (Hoyert, 2022, 2023; Gunja et al., 2022; Hamilton et al., 2022; Simmons-Duffin & Wroth, 2023). Severe maternal morbidity (SMM)—unexpected complications during labor and delivery—affects 50,000 to 60,000 women annually, with Black women more than twice as likely to experience it (CDC, 2023). The Centers for Disease Control and Prevention’s (CDC) definition of SMM reflects these numbers but underestimates the burden—as they exclude prenatal and postpartum morbidities which dramatically increase the risk of adverse outcomes (Declercq & Zephyrin, 2021).

Prenatal and postpartum morbidities such as hypertension, preeclampsia, posttraumatic stress disorder (PTSD), hemorrhage, and sepsis disproportionately affect Black women across the perinatal timeline (Declercq & Zephyrin, 2021; Gilles & Cayo, 2021; Seng, 2011). Black women face a 60% higher rate of preeclampsia (Fingar et al., 2017) and are 50% less likely to be diagnosed with endometriosis (Nuffield Department, 2023).

The consequences of macro-level inequities extend to infants. Black women have a preterm birth rate of 14.13%, compared to 9.09% among white women, and a stillbirth rate more than double that of their white

counterparts (Martin et al., 2019; Eldeib, 2022). In addition, Black women experience twice the rate of fetal and infant death compared to white women (Bommaraju et al., 2016). In 2021 alone, Black infants accounted for 7,621 preterm births (Hamilton et al., 2022). These outcomes reflect not isolated incidents but a pattern of harm perpetuated by inequitable policies, underinvestment in Black maternal health, and a healthcare system failing those most vulnerable.

Macro-Systemic Harm in Black Maternal Health: Legislation and Policy

Legislation—classified as macro-systemic—governs the distribution of care, resources, and protections. When these measures fail, it reinforces the systemic disparities for marginalized groups such as Black women. The Hill-Burton Act of 1946 led to segregated, underfunded hospitals in Black communities, which continues to shape access today (Largent, 2018). Title VI of the Civil Rights Act (1964) aimed to eliminate racial discrimination in federally funded healthcare but has suffered from weak enforcement (Tyler, 2022). Meanwhile, Medicaid, which covers 66% of births to Black women, limits postpartum coverage to just 60 days, leaving many without care during critical recovery (Tyler, 2022). These failures and structural gaps reflect how these longstanding policy failures continue to drive macro-level inequities in Black maternal health.

Historical Macro-Systemic Harm in Black Maternal Health

Historical macro-systemic harm refers to the lasting impact of past policies, practices, and structures. For healthcare, this would include the reproductive oppression and abuse of Black women throughout U.S. history. Black women, particularly those who were enslaved, were subjected to non-consensual medical experimentation and forced breeding. The aim was to increase the enslaved population for economic gain and for maternal healthcare advancements that benefited upper-class white women. These practices included medical experimentation without anesthesia, forced breeding, and eugenics practices—all of which stemmed from deeply entrenched beliefs in racial inferiority (Taylor, 2020, pp. 508–510; Buckles & Ives-Ruble, 2022; Hostetter & Klein, 2021). This history of cruelty and exploitation has contributed to a legacy of mistrust in healthcare systems that disproportionately harms Black women today.

Macro-Systemic Harm Caused by Policy Reversals in Reproductive Healthcare

Part of the macro-systemic harm includes healthcare policy reversals—those that involve rolling back protections or rights—that have exacerbated the systemic inequities, worsening the healthcare outcomes for marginalized groups. This is exemplified by the 2022 overturning of *Roe v. Wade*, which has amplified Black maternal health inequities. *Roe v. Wade*—legalized in 1973—significantly reduced non-white maternal mortality by 30–40%, preventing

an estimated 113 non-white maternal deaths in its first year of implementation (Farin et al., 2021), and helped alleviate macro-level disparities by safeguarding reproductive rights. The 2022 Supreme Court decision to overturn *Roe v. Wade* dismantled these protections. States with restrictive abortion laws now report maternal mortality rates averaging 28.5 deaths per 100,000 births, compared to 15.7 in states that protect abortion rights (Ducharme, 2022), with projections estimating a 24% nationwide increase in maternal mortality and a 39% rise among Black women if abortion were banned in their state of residence (Vilda et al., 2021; Damante & Jones, 2023). The outcomes from the policy reversal of *Roe v. Wade* illustrate the harms that deepen structural inequities in Black maternal health.

Mezzo-Level Harm in Black Maternal Health

Mezzo-level harms occur within institutions and organizations—such as hospitals, schools, and neighborhood systems—influencing outcomes for specific communities or population groups. In regard to maternal health, this refers to the accessibility and quality of hospitals and clinics that directly affect groups and communities. Hospitals in predominantly Black neighborhoods—particularly in rural areas or urban maternity care deserts—often face resource constraints. As Taylor (2019) defined, maternity care deserts are regions with limited or no access to obstetric services due to a shortage

of healthcare providers or barriers like insurance and transportation. More than 12% of U.S. births occur in these areas, and Black women, who are more likely to live in these underserved regions, face heightened challenges as a result (Taylor, 2019). The closure of maternity wards, such as those in Washington, D.C., serving predominantly African American residents, further limits access to essential care (Taylor, 2019).

Poor Black maternal health outcomes related to limited access are further exacerbated by the lower quality of care in hospitals. A California study found that, even after controlling for sociodemographic and pregnancy-related factors, Black women faced higher rates of severe maternal morbidity—primarily due to delivery in lower-quality hospitals with higher concentrations of Black births (Mujahid et al., 2021). This underscores how institutional neglect within Black-serving hospitals directly contributes to disproportionate maternal harm.

Micro-System: Implicit Bias and Maternal Health Outcomes for Black Women

Micro-systems are direct, individual-level interactions. In Black maternal healthcare, this may include the implicit bias in individual-level patient-provider dynamics. Implicit bias includes labeling Black mothers as “non-compliant” or “difficult,” thereby dismissing their symptoms, leading to their delayed diagnoses, inadequate care, and worsened outcomes (Tyler, 2022).

These experiences also carry a profound psychological toll. Black women who report racial discrimination during pregnancy also experience significantly higher psychological distress. This impedes their ability to advocate for themselves and access timely treatment (Giurgescu et al., 2017). Their stress contributes to avoidable health complications and deepens mistrust. Notably, 22% of Black women avoid seeking care altogether due to anticipated racial and gender discrimination (Tyler, 2022). These micro-level interactions, shaped by bias and distrust, are not isolated—they are central to the systemic deterioration of Black maternal health.

The Role of Social Workers in Addressing Macro-, Mezzo-, and Micro-Level Disparities

The skills and principles of social work are essential for addressing the macro-, mezzo-, and micro-level challenges of Black maternal health. These challenges require non-traditional, systems-based approaches that prioritize holistic, context-driven solutions. At the macro-level, social workers bring expertise in social justice and policy analysis to confront the root causes of inequities—often ignored by systems focused on short-term fixes. Their commitment to empowerment and human dignity ensures marginalized communities are centered in policy reform aimed at long-term change. At the mezzo-level, social workers operate within healthcare institutions and communities to promote cultural competence, advocate for equitable care, and expand access—especially in

underserved areas. Their strengths in program development and community organizing help dismantle institutional barriers and tailor care to the needs of Black women. On the micro-level, social workers offer trauma-informed care, case management, and emotional support to counteract the effects of implicit bias and medical neglect. By advocating for patient rights and providing direct support, they help Black women receive respectful, timely care in systems that often fail them. From policy reform to community engagement to individual care, social workers play a critical role in closing maternal health gaps and advancing equity across all levels.

Addressing Macro-, Mezzo-, and Micro-Level Disparities Through Midwifery

Midwifery care addresses maternal health disparities across the macro-, mezzo-, and micro-levels. At the macro-level, midwives contribute to systemic reform by improving outcomes, lowering costs, and expanding access—particularly in marginalized communities. In countries with well-integrated midwifery systems, such as Australia and Sweden, maternal mortality rates are significantly lower, with midwives delivering the most essential perinatal care (Tikkanen et al., 2020). Globally, midwifery-led care could meet 80% of maternal care needs, reducing maternal mortality by 41% and neonatal mortality by 39% (Niles & Zephyrin, 2023). In the U.S., where maternal mortality is the highest among developed nations, states like Oregon and Washington—with higher midwifery

integration—report better maternal and infant health outcomes (Vedam et al., 2018). Without national adoption, midwifery remains underutilized.

At the mezzo-level, midwifery care addresses healthcare disparities through community-based, culturally competent care models. One such example is the Melanated Group Midwifery Care (MGMC) model, which improves patient engagement, reduces preterm birth, and enhances postpartum outcomes by fostering community support and trust (Liese et al., 2022). Furthermore, racial concordance is a key factor in the implementation of midwifery. Notably, 83% of Black patients prefer race-concordant providers due to increased trust, cultural humility, and communication (Moore et al., 2021). Midwifery models that prioritize these dynamics are critical to rebuilding trust in healthcare systems.

At the micro-level, midwifery provides individualized support by respecting cultural values and focusing on patient-centered care. Importantly, midwifery respects cultural values and minimizes unnecessary interventions—like C-sections (LoGiudice, 2022; Niles & Zephyrin, 2023). By fostering trust and reducing adversarial dynamics, midwives help mitigate the effects of implicit bias and discrimination. Additionally, the MGMC model, which includes components like group prenatal care and postpartum doula support, offers tailored care that strengthens the patient-provider relationship and encourages

greater participation in decision-making (Liese et al., 2022). These culturally responsive approaches directly support the physical and emotional health of Black women and address long-standing disparities in care.

Proposed Policy Solution Draft: Nurse Midwifery Program Expansion Initiative to Address Racial Disparities in Maternal and Perinatal Health

The Nurse Midwifery Program Expansion Initiative will address systemic inequities driving poor maternal health outcomes for Black women by targeting the micro-, mezzo-, and macro-levels of care. To clarify, certified nurse-midwives (CNMs) are advanced practice providers trained to deliver independent, comprehensive care, including pregnancy, childbirth, postpartum, sexual and reproductive health, gynecology, family planning, primary care, and newborn care through the first 28 days of life (American College of Nurse-Midwives, 2021). The policy will expand access to CNMs providing culturally competent and individualized maternal care. The integration of midwives will foster patient-provider trust, improving clinical communication and trust.

At the mezzo-level, the initiative will diversify the midwifery workforce by funding scholarships for underrepresented students and creating recruitment pipelines with Historically Black Colleges and Universities (HBCUs) and similar institutions. This will expand clinical placements in underserved communities. With

only 7.3% of certified midwives identifying as Black (American Midwifery Certification Board, 2021), this approach promotes racial concordance—an evidence-based strategy that has improved satisfaction, trust, and outcomes. Integrating midwifery within community-based health infrastructures will reduce access barriers and bring care closer to marginalized populations.

At the macro-level, the policy aims to allocate funding from the Health Resources and Services Administration (HRSA) to launch nurse-midwifery programs at accredited nursing schools, specifically prioritizing HBCUs and institutions serving underrepresented students. Resource allocations will support program development, faculty recruitment, curriculum design, and student support. Rigorous evaluation and stakeholder collaboration will ensure alignment with national maternal health equity goals. The initiative also integrates key provisions from the Momnibus Act, including workforce diversification, mentorship for Black midwifery students, and expanded community-based care (Underwood et al., 2023). These macro-level reforms aim to reduce maternal health disparities through a sustainable, equity-driven model. These strategic-level interventions will reduce maternal health disparities across all dimensions of care.

Integration and Inspiration from the Black Maternal Health Momnibus Act

The Black Maternal Health Momnibus Act (2021) is a comprehensive legislative framework that addresses maternal health disparities through culturally competent care, telehealth access, workforce diversification, and community-based support. Several provisions from this act will directly influence sectors of the proposed policy. For example, Section 301 calls for increased funding to community-based organizations—a priority this proposal reinforces by centering midwifery-led care. Section 501 supports the integration of globally trained midwives, which is mirrored through structured mentorship and clinical placements for Black midwifery students. Section 758 promotes perinatal workforce grants, which this proposal advances by embedding equity-focused recruitment and job placement strategies (Underwood et al., 2023). Though the Momnibus Act has not yet been fully passed, its provisions provide precedent and momentum for Black maternal health equity. For example, some provisions are incorporated into the American Rescue Plan (Barnes et al., 2021). This initiative builds on that foundation with a targeted, implementation-ready strategy focused on expanding Black midwifery care to improve Black maternal health outcomes.

Collaboration with HRSA to Form Guidelines

The policy proposal aims to secure federal funding from the Health Resources and Services Administration (HRSA) to support

accredited nursing schools in establishing nurse-midwifery programs. A partnership between HRSA and participating nursing schools will also develop comprehensive guidelines for funding allocation, including budgets for faculty support, curriculum development, clinical training, and student scholarships or stipends. To further ensure sustained HRSA investment and effective use of federal funds, a performance-based evaluation system will track key metrics, including enrollment, graduation, certification exam pass rates, placement in underserved areas, and patient care impact. Programs will submit annual reports and undergo biannual reviews by an oversight committee—composed of HRSA officials, nursing school representatives, certified nurse-midwives, and community health advocates—to ensure alignment with program goals, national educational standards, and maternal health equity outcomes.

Role of Social Workers: Equity-Focused Policy Design

Macro-level social workers with maternal health and racial equity backgrounds can advise on HRSA's funding and program guidelines. Their input is especially valuable in integrating trauma-informed principles, cultural humility, and anti-oppressive frameworks into curricular expectations, faculty training, and community partnership standards. Social workers can also help define non-traditional success indicators—such as patient trust, culturally responsive care, and relationship-building within communities—

that go beyond graduation or employment metrics. Their contributions ensure that HRSA's framework prioritizes technical quality and community alignment.

Independent Annual Measure of Program Outcomes and Impact

To complement HRSA's internal oversight, the National Institute on Minority Health and Health Disparities (NIMHD) would fund independent research to evaluate long-term program outcomes. This assessment would include metrics such as enrollment, student and faculty diversity, graduation and employment rates, community engagement, and satisfaction. The HRSA would be responsible for approving these metrics and overseeing their implementation, as this is a collaborative effort.

Role of Social Workers: Program Evaluation & Community Accountability

Social workers with backgrounds in participatory research and program evaluation can help assess whether midwifery programs effectively serve marginalized communities. In collaboration with HRSA and NIMHD, they can design and implement mixed-methods evaluations, including focus groups with patients, interviews with midwifery students, and longitudinal tracking of health outcomes in communities served. Additionally, social workers can facilitate community review boards or listening sessions to ensure feedback loops are built into the evaluation process, helping programs adapt responsively. Their work ensures

the policy remains accountable to the populations it was designed to benefit.

Encouraging Accredited Nursing Schools to Apply

The proposed policy invites accredited nursing schools to apply for funding to establish nurse-midwifery programs supported by a multi-step implementation strategy. The first step involves two years of financial support—funded by the Health Resources and Services Administration (HRSA)—to help schools address development barriers such as curriculum design, faculty recruitment, and clinical training. Seed grants or pilot programs will allow schools to test midwifery models on a smaller scale before full implementation. Collaborative partnerships will be encouraged to integrate midwifery programs into existing nursing curricula by sharing resources, faculty expertise, and opportunities for interdisciplinary learning. Flexible program design will further incentivize participation, allowing schools to tailor curricula to institutional strengths, regional health priorities, and community needs. Offering professional development for midwifery faculty will also expand women's health education capacity. Finally, funding will prioritize schools with a demonstrated commitment to maternal health, adequate infrastructure, and strategic geographic reach to ensure long-term impact.

Role of Social Workers: Institutional Partnership & Student Recruitment

Social workers in academic and public health settings can support nursing schools during the application process by conducting targeted needs assessments in collaboration with faculty. Through interviews, surveys, and community data analysis, they can help ensure that proposed midwifery programs align with the specific needs of Black and underserved birthing populations. Social workers can also lead recruitment efforts focused on students from historically marginalized backgrounds, including first-generation college students, Medicaid recipients, and those from rural or medically underserved areas. Their involvement helps embed equity into the program design, ensuring it is central to implementation rather than a secondary consideration.

Application Process and Eligibility for Accredited Nursing Schools

I propose collaborating with HRSA to develop a structured application and eligibility framework for nursing schools seeking to establish midwifery programs. Eligibility would be based on criteria including alignment with national standards for nurse-midwifery education, faculty qualifications, capacity to serve underserved or rural communities, partnerships with clinical training facilities and healthcare institutions, plans for promoting diversity and inclusion, commitment to ongoing collaboration with HRSA, plans for continuous program assessment and evaluation, and a detailed budget and resource allocation from federal funding.

Role of Social Workers: Application Review & Community Vetting

Social workers engaged in policy implementation or serving on review committees can assist HRSA in evaluating applications by reviewing how well-proposed programs reflect a commitment to community engagement, racial equity, and health justice. They can vet the authenticity of proposed partnerships with community organizations, assess recruitment plans targeting diverse student populations, and ensure that budgets reflect equitable resource distribution. Their perspective is critical in determining whether applicants are substantively advancing the policy's equity goals or meeting baseline compliance standards for funding eligibility.

Strategy for Advocacy Methods

A comprehensive advocacy strategy is essential to advance the proposed nurse-midwifery program expansion. Public awareness campaigns—through social media and community events—will help promote the policy. Engaging key stakeholders, such as the American College of Nurse-Midwives (ACNM), Midwives Alliance of North America (MANA), National Association of Certified Professional Midwives (NACPM), Improving Birth, White Ribbon Alliance, and Childbirth Connection, will foster collaboration and align efforts with industry standards. Targeted advocacy letters to maternal health policymakers—such as Representative Alma Adams, who serves North

Carolina’s 12th District and co-chairs the Black Maternal Health Caucus—can further influence legislative support. Additionally, submitting the policy proposal to reputable think tanks, like the Center for American Progress, or well-established healthcare foundations, such as the Commonwealth Fund, will facilitate in-depth analysis, critiques, and potential publication. These advocacy efforts will strengthen public engagement, stakeholder collaboration, and targeted partnerships to advance the policy.

Role of Social Workers: Legislative Advocacy & Coalition Building

Social workers in advocacy organizations, policy institutes, or legislative offices will lead key advocacy efforts supporting this initiative. They can draft policy briefs and public testimony, coordinate letter-writing campaigns to members of Congress, and help organize meetings with lawmakers in partnership with maternal health coalitions. With their training in systems-level change and community engagement, social workers are uniquely positioned to connect the priorities of affected communities with the policymaking process, ensuring that Black maternal health remains central to legislative action.

Anticipated Impact

The Nurse Midwifery Program Expansion Initiative aims to reduce Black maternal health disparities by fostering culturally responsive, community-based care. Expanding access to certified nurse-midwives will improve

individualized care and help counter implicit bias, addressing provider mistrust and inadequate clinical response at the micro-level. At the mezzo-level, building a more diverse midwifery workforce and integrating programs into underserved communities will strengthen care continuity, increase patient engagement, and close institutional gaps in quality and access. At the macro-level, federal investment through HRSA will support structural change by funding program development, curriculum reform, and scholarships aligned with national maternal health equity goals. Together, these efforts seek to reduce preventable maternal morbidity and mortality and build a more equitable, sustainable system for Black birthing people. Expanding midwifery access is a public health imperative and a necessary step toward reproductive justice and the dismantling of systemic racial inequities in maternal health.

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The Florida Project: A Case Study¹

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Introduction

“The Florida Project” depicts the life and experience of Moonee and her mother Halley during the summer that Halley’s financial options run out. Although the movie ends with a call to Florida’s Department of Children and Families (DCF) and Moonee being removed from Halley’s care, the reparative work has just begun. This essay first discusses Moonee’s history, presenting concerns, and the effects that environmental interactions have had on her. Next, observations during play therapy are shared, which are followed by an exploration of theoretical explanations for Moonee’s behavior, utilizing object relations theories, Vygotsky’s sociocultural theory, and Kohlberg’s theory of moral development. To conclude, recommendations for treatment in the form of a scripted dialogue for Moonee’s foster parents and caseworker, a case conceptualization, and a formal treatment plan are provided.

History and Presenting Concerns

Moonee is a six-year-old Caucasian female who was removed from her mother Halley’s care after a call was made to DCF about Halley engaging in prostitution while her daughter was in the room. The whereabouts and identity of Moonee’s biological father and

Halley’s relatives are unknown. There is no involvement or support from other family members. Halley has previously been involved in the criminal justice system, with at least one prior arrest. Until recently Halley was working at a strip club but was let go after refusing to “do extras” with clients. Halley was receiving financial assistance through Temporary Assistance for Needy Families (TANF), but this discontinued after Halley lost her employment.

Halley and Moonee lived together in one room at a low-fee motel near Disneyworld in Florida. Many of the other residents of the motel have limited incomes while drugs, alcohol, and fighting are common occurrences. Moonee has three friends who live at the motel and the neighboring motel: Scooty, Jancey, and Dickey. Moonee and her friends have been on summer break, and their parents allow them to play unsupervised and wander around the area for long periods of time as long as they are together. Moonee and her friends frequently break the motel rules and get into trouble with other adults, although they do not seem bothered by the consequences in the rare scenario where any consequences are enacted.

While Halley struggled to find stable employment, she did maintain a fairly close and

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supportive relationship with Moonee. Moonee was allowed to do almost anything that she wanted to, which did to an extent seem to make up for the real-life difficulties (no money for food) that she and her mother experienced, and thus Moonee enjoyed being with her mom. Halley did not punish Moonee and consistently questioned and challenged authority figures, which Moonee imitated. Moonee was very distraught at having to be removed from her mother's care, indicating the safety she felt and the connection she has with Halley.

Moonee currently experiences several emotional and behavioral difficulties in her foster home placement, particularly in her relationship with her foster mother. During the first week of Moonee's placement, Moonee was very sad, kept to herself, for the most part refrained from talking, and followed the rules in her new home. At the start of the second week, Moonee began to consistently and blatantly defy her foster mother's requests and the rules that were in place. When her foster mother asks Moonee to do something, such as put her snack wrapper in the trash, Moonee defies her. Moonee argues that she does not need to listen to her, and then tells her foster mother to "shut up" if she responds. In addition, Moonee easily loses her temper and is annoyed when her foster mother attempts to invite her to participate in a fun activity like watching a movie. Moonee also began to annoy her foster mother on purpose, even when her foster mother was giving Moonee

space and time alone. For example, Moonee throws paper balls at her foster mom while she does the dishes and Moonee watches a movie on the tablet at the kitchen table.

Since the second week of her placement this behavior has occurred every day and occurs several times each day. Currently in the fourth week of her placement, the behavior is still an issue. It has impacted all aspects of Moonee's daily life, including eating, bathing, brushing her teeth, dressing, going to sleep, and participating in activities. Moonee's overall functioning at home is only mitigated in that she does respond well and complies with her foster father.

Moonee's behaviors are a concern only in the home as she is generally compliant and well-behaved in her interactions with DCF workers.

Additional Information Needed

In order to fully understand Moonee's difficulties, additional information regarding several areas of her life is needed. First, it would be useful to know about Moonee's progress in early childhood and if she met all her developmental milestones. Additionally, it would be helpful to know if Halley was using any substances during her pregnancy with Moonee and if at any point Moonee was directly exposed to or consumed any substances. This information not only would be useful in predicting future difficulties with learning and behavior; but also would indicate the need for more specialized therapy services if Moonee did not meet all her milestones and thus currently

has other developmental difficulties. In line with her developmental history, it would also be helpful to know about Moonee's progress and performance at school. If Moonee has difficulties with specific academic subjects, or even is behind in general, it will be beneficial to target behaviors that are particularly relevant to the school setting and to connect Moonee and Halley to support in the school system.

As mentioned previously, the current whereabouts and level of involvement and awareness of Moonee's father and her extended family, either on Halley's or her father's side of the family, is unknown. The provision of this information would be useful both to determine alternative placements for Moonee, if appropriate, and also for providing more support to Halley. For example, perhaps a family member could provide childcare and supervision for Moonee which would enable Halley to take on stable employment or return to school to better her employment opportunities. In addition, Moonee would benefit from the presence of other adults in her life who have different behavioral patterns than Halley, which would provide Moonee with different models of engaging with others.

Environmental Interactions and Effects

A primary challenge for Moonee regarding her environment is the poverty that she and Halley experience and the difficulty that Halley has in finding stable employment. Halley found herself in increasingly desperate situations

and made choices that were motivated by a desire to keep her and Moonee from experiencing homelessness. A particular challenge for Moonee and Halley is that as a single mother, even if Halley is able to find stable employment, this will mean that she is no longer at home and available to watch Moonee. This would increase Moonee's unsupervised time and would likely further entrench her unproductive behaviors in regards to authority figures. Even if Halley was inclined to discipline Moonee, Halley's new employment would likely decrease the probability, and ability, for there to be much follow-through on any consequences. Moonee's friends, who also found themselves in similar circumstances, did provide some social support and comfort for Moonee. That being said, none were able to provide a different perspective or way of behaving.

Observations During Play Therapy

In play therapy, Moonee readily takes the initiative and invites the therapist to participate in her play activities. Moonee was initially timid in the playroom until she learned that it was a space for her, at which point she began exploring and pulling out various toys. Early in the first session, Moonee began testing the limits by covering her hands in paint and running towards the therapist. After being redirected to the easel, Moonee again tested the limits and went to put her paint-covered hands on the puppets but was successfully redirected. Moonee enjoyed playing with the puppets and dolls and creating scenes

with multiple family members interacting, arguing, and then making up and caring for each other. Moonee seems to enjoy the therapist's attention and relishes at being able to take the lead and direct the play scenes.

Understanding of Moonee's Behavior

While Moonee does meet the behavioral criteria for Oppositional-Defiant Disorder (F91.3) according to DSM-5, her oppositional behavior towards her foster mother has not occurred for a long enough period of time to qualify for a diagnosis (American Psychiatric Association, 2013). That being said, Moonee does meet criteria for Adjustment Disorder with mixed disturbance of emotions and conduct (F43.25) (American Psychiatric Association, 2013). Since Moonee is struggling to adjust to her new surroundings and relationships, the author has chosen a theoretical perspective which takes into account Moonee's relational life and interactions. Object relations theories, which emphasize interactions between individuals and others, and the subsequent ways in which these interactions and relationships are internalized and become a part of the self, provide a useful theoretical foundation to explain Moonee's presenting concerns (Flanagan, 2022).

According to object relations theorists, "defenses" are actions which attempt to control parts of the self and others in order to protect against anxiety (Flanagan, 2022). While Moonee is likely employing many of the defenses, the defense referred to as "splitting" most clearly

describes her behavior towards her foster mother. Splitting is the process in which good and bad aspects of others or the self are experienced as separate and is often observed by thinking that others are "all good or all bad" (Flanagan, 2022). In Moonee's case, out of a desire to ward off the anxiety of potentially losing her relationship with her biological mother, and in turn an aspect of herself, Moonee seems to see her foster mother as "all bad." Moonee's consistent opposition could be seen as an attempt to establish control, both of her situation and of her internal world.

While Moonee's oppositional and defiant behavior is most pronounced in its severity and frequency in her relationship with her foster mother, it is by no means contained to only this one authority figure. Moonee seems to have learned from Halley that authority figures do not need to be respected and that there are little to no consequences for one's actions. This understanding, and the way in which it was passed on from Halley to Moonee, is in accordance with Vygotsky's sociocultural theory of cognitive development, which describes how "more knowledgeable others" (usually a significant adult in a child's life) impart to children both what to think and how to think (McLeod, 2024). In short, these significant adults impart the meaning of objects, events, and experiences to children (McLeod, 2024). From Halley, Moonee has learned that authority figures, limits, and rules do not need to be

respected or followed, and that in a sense they are meaningless. In turn, Moonee will follow instructions only to the extent that they align with what she already wanted to do.

According to Kohlberg's theory of moral development, Moonee would still be considered to be in the middle of the earliest stage of moral development, referred to as "Preconventional Morality" (Cherry, 2022). According to Kohlberg's theory, during this stage children's decisions concerning what is right and wrong are shaped by the expectations of other adults and the consequences that are in place if one breaks the rules (Cherry, 2022). Moonee, who for the most part is never punished, seems to have an underdeveloped sense of morality due to the lack of consequences for her actions. It seems that to Moonee what is "right" is what she would like to do, and "wrong" would be whatever she does not want to do. Now that Moonee finds herself in a more stable and consistent setting with her foster parents, where there are rules and consequences, Moonee's moral framework is colliding with the reality she faces. Moonee's opposition to authority could be considered to also be a moral objection (from Moonee's perspective), in that what her foster mother is attempting to do by laying out and enforcing rules is considered by Moonee to be "wrong."

Treatment Plan for Foster Parents & Caseworker

The following is a scripted dialogue of what the author would say in making

recommendations for Moonee's treatment plan to her foster parents and caseworker: "It is clear that Moonee has difficulties with authority figures in general, but particularly with you, her foster mother. My recommendation is that we take an integrated therapy approach that includes both nondirective and directive techniques. What this means is that for approximately the first half of therapy, I will use child-centered play therapy with Moonee, where she will direct the play and be able to express and process her feelings. During this time, my goal will be for Moonee's oppositional behavior to decrease, especially in her interactions with you, her foster mother. My job will primarily be to establish a relationship with Moonee that is based on genuineness, warmth, acceptance, and sensitive understanding. In addition to Moonee forming a more secure attachment to an adult, in this play therapy I will also be focusing on setting and enforcing consistent limits. Although I expect this to be a challenge with Moonee, the playroom is the perfect setting for her to practice pushing on and accepting limits."

"After the relationship has been established and Moonee has improved in accepting limits, we will transition to a directive approach. The goal of this time will be for Moonee to develop respectful and cooperative responses to rules and requests. Moonee and I will play board games as a means to practice identifying and following rules as well as begin noticing what situations make her frustrated and

angry. Next, using puppets or miniatures, we will role play situations at home that make her feel frustrated or angry and then explore alternative ways of responding to rules and requests.”

Case Conceptualization

Particularly when directed towards her foster mother, the root of Moonee’s oppositional and defiant behaviors can be conceptualized as a defense against the loss of Moonee’s biological mother, and to an extent, Moonee’s self (Flanagan, 2022). In order to defend against this threat, Moonee utilizes “splitting” to see her foster mother as “all bad,” which in turn permits Moonee to defy and intentionally annoy her (Flanagan, 2022). In order for Moonee to move beyond this understanding of her relationship with her foster mother, it will be useful for Moonee to have the experience of a relationship with an adult where Moonee can experience this adult as having both “good” and “bad” qualities, and yet still being consistent, supportive, and accepting (Landreth, 2012). The relationship established in child-centered play therapy will be an effective way of creating this relational experience (Landreth, 2012). Moonee will likely experience the play therapist as “good” to the extent that he permits her to play how she would like, and then conversely as “bad” when he sets any limits on her behavior.

Transitioning to a more directive approach that incorporates games and role playing is essentially an extended practice for Moonee to continue accepting limits with a

caring and supportive adult (Swank, 2008). While the limits set in the play therapy are minimal, in the board game and the role plays, limits will likely be experienced as more constricting.

Moonee’s difficulties in accepting these increasingly constricting limits will be supported by the relationship with the therapist. As Moonee becomes more comfortable in accepting limits with the therapist, she should in turn become more comfortable with her relationship with her foster mother, exhibiting less oppositional behavior and more respectful and cooperative behavior. Moonee’s anxiety of losing her biological mother and in turn an aspect of herself should be alleviated by the expression permitted in the play therapy and a more secure relationship with her foster mother.

Formal Treatment Plan

Oppositional-Defiant Behavior: Definitions

- Moonee displays a pattern of oppositional and defiant behavior towards most adults, and specifically towards her foster mother
- Moonee often defies and refuses to follow rules and comply with requests
- Moonee is easily annoyed and angered and intentionally annoys her foster mother

Goals for Therapy

- Decrease Moonee’s oppositional behaviors with her foster mother from every day to no more than three times per week

- Replace Moonee’s defiant responses to her foster mother’s requests and rules with cooperative and respectful responses in the majority of their interactions each week which will be measured by entries in the foster mother’s interaction-log for Moonee

Short Term Objectives & Therapeutic Interventions

- Short Term Objective: Establish a therapeutic alliance with Moonee that is based on genuineness, warm caring, acceptance, and empathy (Landreth, 2012).
 - Therapeutic Intervention: Child-centered play therapy sessions in which Moonee experiences a relationship with an understanding, accepting, and supportive adult (Landreth, 2012).
- Short Term Objective: Moonee will successfully accept a limit set by the therapist at the therapist’s first request at least once during each play session.
 - Therapeutic Intervention: During child-centered play therapy sessions, the therapist will set limits on unacceptable behavior by acknowledging Moonee’s feelings being expressed, communicating the limit, and targeting alternative options

(Landreth, 2012).

- Short Term Objective: Moonee will be able to recognize and describe connections between situations, feelings, and oppositional behavior.
 - Therapeutic Intervention: The therapist and Moonee will play board games with the objective of seeing who can follow the rules of the game best in order to win. Moonee and the therapist will discuss the process of playing the game and any feelings that arose for Moonee while playing (Swank, 2008).
- Short Term Objective: Moonee will be able to communicate feelings of frustration, disagreement, and/or anger in a manner that is respectful, controlled, and collaborative.
 - Therapeutic Intervention: Therapist will engage in role play practices with Moonee utilizing puppets and miniatures to simulate conflicts between Moonee and her foster mother (Gil, 2006).

Conclusion

While in the long run Moonee’s removal from Halley’s care was necessary for both Moonee’s safety and for Halley to be able to create a stable home for herself and Moonee, the removal surely had a disruptive effect on

Moonee's internal world. In light of this, her oppositional responses to her foster mother's attempts at parenting Moonee by connecting with her and setting appropriate limits in the household is understandable and to some extent can be expected. Child-centered play therapy provides an adequate setting in which Moonee can both explore and express her feelings about her removal from Halley's care while also developing her own sense of efficacy and learning the safety that consistent limits can provide for her. Working with Moonee will certainly require patience and compassion, but with mutual support from her therapist, caseworker, and foster parents, Moonee should be able to interact more cooperatively and productively with adults as well as develop a stable and secure sense of self.

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