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Affirming Strengths-Based Models of Practice

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PART III

AFFIRMING LGBTQ PRACTICE APPROACHES

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Social Work Practice with the LGBTQ Community : The Intersection of History, Health, Mental Health, and Policy Factors, edited by Michael P. Dentato, Oxford University Press, Incorporated, 2017. ProQuest Ebook Central, http://ebookcentral.proquest.com/lib/luc/detail.action?docID=5061687.
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CHAPTER 11

AFFIRMING AND STRENGTHS-BASED MODELS OF PRACTICE

Trevor G. Gates and Brian L. Kelly

INTRODUCTION

Affirming and strengths-based practice with lesbian, gay, bisexual, transgender, and queer (LGBTQ) individuals and communities started to become more mainstream in the 1970s and 1980s and continues today. Whereas stigmatization of LGBTQ individuals and communities was once the accepted norm, most mainstream professional organizations in social work and allied helping professions today treat LGBTQ identity as part of the normal spectrum of human experience and support affirming and strengths-based models of practice with LGBTQ communities (American Counseling Association, 2013; American Psychological Association [APA], 2008; Council on Social Work Education [CSWE], 2015; National Association of Social Workers, 2005). In this chapter, we describe affirming and strengths-based practice with LGBTQ individuals and communities and consider the context in which these practice models emerged. Additionally, we explore the various theoretical and practice models that are the foundation of affirming and strengths-based practice with LGBTQ communities and consider the efficacy of these service approaches.

DEFINING AFFIRMING AND STRENGTHS-BASED PRACTICE

LGBTQ-affirmative and strengths-based practice refers to the range of practice models that create a safe, supportive environment for individuals to express their sexual orientation and varied

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gender identities and expressions. Grounded in the assumption that LGBTQ identities are normal and expected parts of the human experience, LGBTQ-affirmative practice acknowledges and affirms individuals' identities without assuming the individual is "struggling" with their identity or that the core of the individual's psychosocial issues is related to sexual orientation or gender identity and expression (Van Den Bergh & Crisp, 2002). Rather, affirmative social workers acknowledge LGBTQ identities as an important part of life that may or may not be directly impacting the client's presenting issues and work to help clients integrate their LGBTQ identities with the rest of their life (Lebolt, 1999; Malyon, 1982).

Affirmative and strengths-based practice models also acknowledge that, while LGBTQ individuals may seek services when experiencing pain, stress, and losses, they have a wealth of ideas, competencies, and resources that they can draw upon in their time of need (Munford & Sanders, 2005; Saleebey, 2009). LGBTQ individuals may have experienced injury or have been victimized because of who they are, yet LGBTQ individuals are not victims (Baines, 2007; Gates & Kelly, 2013; Saleebey, 2009). They are capable change-agents who have experiences from which they can draw from (Dominelli, 2002; Weick, Kreider, & Chamberlain, 2009) for coping, adaptation, and resilience.

Likewise, affirmative and strengths-based practice means that the practitioner openly supports all LGBTQ individuals and communities. LGBTQ affirmative practice approaches celebrate sexual orientation and gender identity/expression, promote cultural competence in working with LGBTQ communities, and provide judgment-free spaces for LGBTQ clients to explore who they are (Crisp & McCave, 2007; Hill, 2009; Yarlzouse & Beckstead, 2011). Social workers who use LGBTQ-affirmative practice approaches recognize that, while some LGBTQ people have experienced challenges as a result of their environment, overall LGBTQ individuals are resilient and able to overcome these challenges (Crisp & McCave, 2007; Kort, 2008). LGBTQ identities are not aberrations or a problem; they are, in fact, quite ordinary. Affirmative and strengths-based practice blends the micro, mezzo, and macro by supporting individual LGBTQ individuals while actively speaking out when individuals, groups, institutions, and communities treat them with less than the full dignity they deserve.

HISTORICAL INFLUENCES

Serving LGBTQ individuals with dignity has not always been the social and cultural norm. Practice approaches that affirm LGBTQ identities are, more or less, recent phenomena within the helping professions. These approaches have been shaped by sociohistorical factors, as well as scholarship and research over the last fifty years.

DECLASSIFICATION OF HOMOSEXUALITY FROM THE DSM

Prior to the 1970s, homosexuality was classified as a mental illness in the APA's *Diagnostic and Statistical Manual for Mental Disorders* (DSM), which is widely utilized for mental health

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classification. In 1973, homosexuality was officially declassified as a mental illness. The third edition of the DSM reclassified sexual orientation disturbance as ego-dystonic homosexuality, a mental health disorder only when the individual experiences distress because of his or her same-sex desire (APA, 1980). Eventually, ego-dystonic homosexuality was removed (APA, 1994; Stein, 2001). However, gender identity and expression variance remain represented in the DSM. In the fifth edition, gender dysphoria results when individuals experience a conflict between their birth sex and their gender identity, resulting in clinically significant impairment in functioning (APA, 2013). Presence of a diagnosis in the DSM helps some transgender people demonstrate the "medical necessity" of chemical transition (hormone therapy or other procedures that assist with feminization or masculinization of the body), surgical transition (sexual reassignment surgery/gender confirmation surgery, including phalloplasty, vaginoplasty, and breast enhancement or reduction), and other services that help makes the body consistent with the individual's identified gender identity. Yet the gender dysphoria diagnosis continues to be challenging in that it unnecessarily pathologizes gender variance instead of seeing gender variance as a normal part of the human experience.

A small but enduring group of mental health professionals continues to see LGBTQ behavior and identity as problematic. For example, organizations such as National Association for Research and Therapy of Homosexuality (NARTH) and the now-defunct Exodus International support the practice of conversion, reparative, or ex-gay therapies, which purport to help individuals change their sexual orientation identities into heterosexual ones (Bright, 2007). NARTH (2015) believes that such as LGBTQ individuals have the right to claim their identity, that people who wish to "diminish their homosexuality and to develop their heterosexual potential" should have the right to do so without being stigmatized. They believe that LGBTQ individuals should have the right to choose from "all relevant therapeutic options" and particularly the right to suppress LGBTQ identities if they so choose (Kaufman, 2001, p. 441).

Yet most mainstream professional helping organizations state that sexual orientation change efforts are ineffective and harmful (American Counseling Association, 2013; APA, 2008; CSWE, 2015; National Association of Social Workers, 2005). Further, CSWE and its Council on Sexual Orientation and Gender Identity and Expression advocate against teaching conversion or ex-gay therapies in accredited bachelor's and master's level social work programs, in large part because of their incompatibility with CSWE Educational Policy and Accreditation Standards (CSWE, 2015). Several jurisdictions in the United States currently ban conversion therapy, particularly with minors (Steinmetz, 2015). To date, the US Supreme Court has refused to hear challenges of those bans, and social workers and other mental health professionals in California, Illinois, New Jersey, and Oregon may not provide conversion therapy to minors (Miller, 2015).

IDENTITY DEVELOPMENT MODELS USEFUL FOR AFFIRMING PRACTICE

Perhaps one of the most commonly cited contributions to LGBTQ affirming and strengths-based practice is the Cass model of homosexuality development. Cass (1984) proposed a six-stage model for sexual minority identity development, including identity confusion, identity comparison,

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tolerance, acceptance, pride, and synthesis. Strengths of the Cass model are that the individual and social worker can process through a variety of stages and there are measurable milestones and goals that can be achieved (Kort, 2008). The Cass model can also be useful for working with a variety of culturally diverse populations with some adaptations (Adams & Phillips, 2009; Degges-White, Rice, & Myers, 2000; Feldman & Wright, 2013).

However, challenges of the Cass model are its linearity and maybe incorrect assumptions about LGBTQ identity development. It assumes that men and women develop their sexual orientation identities similarly and that the experience is the same whether the individual is young or old (Kenneady & Oswalt, 2014; Rickards & Wuest, 2006). The Cass model assumes that the eventual goal is reintegration into a sexual or gender-normative society through synthesis when, in fact, some people may be unwilling or unable to do so. It also at times incorrectly assumes that everyone goes through a period of "confusion." Some LGBTQ individuals are only confused by the reaction of their families and society but never have confusion about their sexual orientation, gender identity, and/or expression.

When the Cass model is less than suitable for an individual's unique circumstances, social workers should make use of other LGBTQ identity development models. For example, a far less linear model is D'Augelli's (1994) homosexual lifespan development model, a model that emphasizes developing a public identity first with friends, family, and then to a larger community. Of course, coming out to a larger community may be what indeed occurs first, especially for people who are never able to pass as straight. They might have dealt with assumptions about their sexual orientation throughout their life. Lev's (2004) transgender emergence model, like other models, focuses on coming out to oneself and others while eventually exploring options for transitioning in appearance and/or body, to include, sometimes, physical or hormonal efforts to make the physical body congruent with the person's unique sense of gender identity and expression. Similar to the Cass model, reintegration and synthesis into society are the eventual goal of the transgender emergence model (Cass, 1984; Lev, 2004). For more information on these models of LGBTQ identity development, see chapter 4 in this text.

SEXUAL LIBERATION, HIV/AIDS, AND SEX POSITIVE INTERVENTIONS

Paving the way for affirmative practice has been the emergence of LGBTQ activism and sexual liberation movements during the twentieth century. These movements have been widely studied by scholars of LGBTQ history. Chauncey (1994) chronicles thriving same-sex desire communities in New York during the late nineteenth and early twentieth century. Boyd (2003) describes a bustling lesbian community in post–World War II San Francisco, where bars and softball leagues served important community-building roles. D'Emilio (1998) traces the work of the homophile movement during the 1950s and 1960s, a movement that made significant strides in creating spaces for homosexuals and lesbians to connect, at times for social reasons and at other times to challenge, fight, march, and speak out against the discrimination and prejudice enacted on them by the dominant heterosexist and homophobic culture. These historiographies highlight the important ways in which same-sex loving men and women throughout the first half of the twentieth century

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laid the foundation for significant cultural and political changes to follow in the second half of the century. In fact, D'Emilio (1998) proposes it was the homophile movement that provided the foundation for the gay liberation movement that followed it in the late 1960s and paved the way for significant LGBTQ activism, particular the Stonewall rebellion. The Stonewall Inn rebellions in Greenwich Village in New York City were a series of spontaneous riots launched by LGBTQ individuals who were responding to mistreatment by the police at the popular bar and nightclub.

A milestone in the LGBTQ rights movement, the Stonewall rebellion catalyzed a more radical, less apologetic voice in fledging LGBTQ communities of the time and become an iconic symbol of LGBTQ liberation. This unapologetic voice proactively challenged stigmatizing conceptions of LGBTQ love, relationships, and sex. The sexual revolution of the 1970s that followed opened doors for LGBTQ individuals that prior to that point were unimaginable. A platform grounded in the New Left (i.e., a political movement of the late 1960s and early 1970s that promoted civil and gender equality rights) and Gay Liberation Fronts (i.e., offshoots of the New Left focused on gay rights—see Wittman, 1997) exploded in urban areas along the coasts in cities like New York and San Francisco. As a result, many gay men experienced new and open forms of sexual freedom and liberation. Several authors of various political inclinations have documented this time period. Kramer (1978) somewhat scathingly documents this era of new and unbridled gay male sexuality made easier and more accessible through bathhouses, while Berkowitz (2003) and Feinberg (1989) describe an era of sexual liberation, albeit with consequences, including the proliferation of sexually transmitted diseases among populations of gay men. These authors describe the sexual liberation of the gay male community without sugarcoating the consequences of their behaviors, which was often sickness and disease. Still, many gay men protected their newfound sexual liberation, despite some of the consequences it presented. In this milieu, many men contracted and transmitted what would eventually be known as HIV and AIDS.

In 1983, Larry Kramer published the now infamous essay, *1,112 and Counting* (Kramer, 1989). It served as a call to action to address the then mysterious named disease, gay related immune deficiency (GRID), which was rapidly killing many gay men. It is important to note, though, that several scholars argue that other oppressed populations, including intravenous drug users, women, individuals of color, and the poor, were equally affected in the early days of the epidemic (Brier, 2009; Cohen, 1999; Treichler, 1999). As the HIV/AIDS epidemic spread throughout the 1980s, LGBTQ individuals and communities created strong and resilient networks of support. Grassroots efforts to care for, feed, and shelter those living with HIV/AIDS rose up across the nation to combat the homophobic fear and heterosexism that plagued the early years of the epidemic. Many of these grassroots efforts blossomed into local, statewide, and national advocacy campaigns, including the Gay Men's Health Crisis (see Byron, 1997) and Act Up (see Kramer, 1997). These campaigns sought to increase awareness and demand federal support for life-saving services and treatments, a necessary effort as the federal government all but ignored the epidemic until 1987 (Brier, 2009).

While the health and lives of LGBTQ individuals and communities were threatened and at times devastated by the HIV/AIDS epidemic, strength and resilience ultimately prevailed. LGBTQ communities, standing on the foundation of the homophile movement, Stonewall, the New Left and Gay Liberation Fronts, and the sexual liberation of the 1970s, demanded visibility and humane medical treatment and care. Since the mid-1990s, the outlook for those living

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with HIV and AIDS has vitally changed due to the valiant efforts of LGBTQ advocates and allied communities.

One of the more lasting legacies of the HIV/AIDS pandemic is the promotion of safe sex practices. In their landmark 1983 essay, "How to Have Sex in an Epidemic," Berkowitz and Callen (1997) cautioned against gay male sexual promiscuity and promoted safe sex practices, including the use of condoms. They contended that safe sex practices offered the best way to engage in sex in the era of life threatening sexually transmitted infections. While criticized by many as paranoid and puritanical at the time, this essay and the work of others provided a foundation for safe sex movements within LGBTQ and non-LGBTQ communities that have saved millions of lives. The safe sex movement continues to expand and grow as LGBTQ individuals and communities advocate for and promote sex positive attitudes toward HIV/AIDS prevention. Efforts include the promotion of condom use between individuals who are HIV-positive and individuals who are HIV-negative engaging in anal or vaginal intercourse. In addition, proponents of safe sex practices incorporate harm-reduction approaches in their work, which seek to promote the reduction of sexual behaviors that place LGBTQ individuals at risk for HIV and other sexually transmissible infections. Each of these approaches affirm LGBTQ sexual expression, while prioritizing LGBTQ individuals' health and safety. For more information about these health education, prevention, and treatment topics, see chapters 20 and 24 in this volume.

COMPLEMENTARY THERAPEUTIC APPROACHES

Several complementary practice approaches can be used or modified as a part of LGBTQ affirmative and strengths-based practice. By drawing on psychodynamic theory, social constructivist, postmodern, and narrative approaches, as well as cognitive-behavioral strategies, practitioners can serve LGBTQ populations in more comprehensive and supportive ways.

PSYCHODYNAMIC THEORY

Psychodynamic practice offers social workers important opportunities to engage LGBTQ individuals from an affirming, strengths-based perspective. While a complete review of psychodynamic theory is beyond the scope of this chapter, it is important to note that it is grounded in the psychoanalytic tradition initially developed by Sigmund Freud and further developed by his followers, including Carl Jung. Psychodynamic practice represents a broader approach to and application of Freud's work, which seeks to treat various forms of psychopathology (e.g., depression, neurosis) through a dialogical process between the individual and his or her social worker (see Freud & Gay [1995] for additional explanation of psychoanalytic theory). Much like the larger social context in which it was developed, many scholars and practitioners of psychodynamic theory framed homosexuality as a form of pathology and perversion throughout much of the twentieth century (Fairbairn, 1952; Winnicott, 1964). This oppressive and discriminatory legacy is best represented

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in the diagnosing of homosexuality as a form of pathology in early versions of the DSM and still lives on today in the attitudes of some analysts trained during the early to mid-twentieth century (Bartlett, King, & Phillips, 2001; Phillips, Bartlett, & King, 2001).

Despite this historical precedent, several current psychodynamic scholars and practitioners have moved beyond framing same-sex desire as pathological and problematic, or at least viewing it essentially as such. Ellis (2005) stresses the dialogical nature of psychodynamic practice and argues that it offers important opportunities for individuals to move beyond potentially pathologizing, causal descriptions of sexual identity to richer, contextualized descriptions of their sexual identity. In this more affirming psychodynamic approach, individuals are invited to consider how their sexual identities intertwine with and/or depart from other identities they embody. Mair and Izzard (2001) theoretically explore the practitioner's role in affirming approaches to psychodynamic practice with LGBTQ individuals, arguing for a person-centered approach that welcomes the whole person into the therapeutic process. This important theoretical work suggests there is greater potential for increased affirming and strengths-based psychodynamic practice with LGBTQ individuals.

A need for a shift in focus from psychoanalysis was first proposed by Austrian-born US psychiatrist Heinz Kohut's movement toward self-psychology. Kohut (1977) argued against a psychiatry based on "pathology" and for an empathic approach that focused less on the ego or individual conscious and unconscious sexual and aggressive impulses (Martin, 2008). Proponents of self-psychology aim to help the individual have a greater realization of self and to experience his or her identity, past, and relationships with maturity and congruence (Flanagan, 2008). Affirmative practice helps LGBTQ individuals make sense of their experiences of heterosexism, homophobia, and other forms of oppression and helps integrate that history into the individual's present identity (Kertzner, 1999). LGBTQ-affirmative social workers may help LGBTQ people coping with past experiences by helping them realize that, though the experience may have felt damaging, they are not a damaged person.

SOCIAL CONSTRUCTIVIST, POSTMODERN, AND NARRATIVE APPROACHES

Constructivist and postmodern approaches to social work practice with LGBTQ individuals offer opportunities for affirmation, as well as strength recognition and building. Grounded in the work of French philosopher Michel Foucault (see Chambon [1999] for further discussion of Foucault's work and its relevance to social work), postmodern and constructivist approaches to social work practice recognize that knowledge is socially constructed through time- and context-bound experiences and the meaning individuals, groups, communities, and systems place on those experiences (Payne, 2014). Within this paradigm, socially constructed knowledge is never static; it always has the potential for change as experiences and meaning attribution evolve over time. As socially constructed knowledge is enacted on, it creates realities that prioritize certain identities and ways of being over others, thereby empowering some groups while disempowering others, and ultimately creating socially constructed systems of power, privilege, and oppression. Postmodern and constructivist approaches to social work practice seek to recognize these dynamics and create opportunities for LGBTQ individuals to give voice to their experiences of oppression while also seeking to create opportunities for them to empower themselves.

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Situated in Foucault's philosophical work and constructivist and postmodern approaches to clinical practice, narrative therapy evolved out of the fields of couple/marriage and family therapy in New Zealand and Australia during the late 1980s (Besley, 2002). Constructivist and postmodern couple/marriage and family therapists seeking to prioritize solutions and individual strengths developed therapist–client collaborative styles, in which clinicians work together with individuals to prioritize their lived experiences and the meaning they attach to their experiences (Walsh, 2012). Narrative therapy is the fullest realization of this model, whereby the practitioner assists individuals in retelling the story of their lives in less problem-driven and more functional and strengths-based ways (Freedman & Combs, 1996; White & Epston, 1990). Social workers practicing with LGBTQ individuals employing the principles of narrative therapy may assist individuals in retelling experiences of internalized homophobia, interpersonal homophobia and heterosexism, and systemic homophobia and heterosexism (Galarza, 2013; Saltzburg, 2007).

COGNITIVE-BEHAVIORAL APPROACHES

Cognitive-behavioral strategies are also helpful for social workers operating from a strengths and affirmative framework in their work with LGBTQ clients. Cognitive-behavioral therapy (CBT) works to develop new patterns of thinking in individuals and new behaviors to accompany those thought changes (Walsh, 2013). CBT is a widely used approach in social work that actively works to change maladaptive ways of thinking and behaving (Butler, Chapman, Forman, & Beck, 2006). CBT has been used with varying degrees of success in helping LGBTQ individuals combat internalized heterosexism, homophobia, and other troublesome thinking patterns in several different treatment studies (Austin & Craig, 2015; Craig, Austin, & Alessi, 2013; Hart, Tulloch, & O'Cleirigh, 2014; Ross, Doctor, Dimito, Kuehl, & Armstrong, 2008).

Social workers using CBT within a strengths and affirming practice paradigm should focus on patterns of thinking and behaving that are functional for LGBTQ individuals. For example, when working to reduce internalized homophobia or heterosexism, social workers should focus attention on hopes, visions, talents, and abilities (Saleebey, 2009) instead of self-defeating thoughts. Remembering and reconnecting with individuals who helped make life interesting and happy (De Jong & Berg, 2002) for the LGBTQ individual may be more productive than ruminating on maintaining relationships with unsupportive individuals. Additionally, helping the LGBTQ individual identify next steps can also be useful, as remaining fixed in negative thoughts and behaviors may hinder locating and connecting with others providing support within the community.

SOCIAL WORK AND GAY-AFFIRMATIVE APPROACHES

Gay-affirmative psychotherapy, which emerged in the 1970s and 1980s from a need for counseling practice that was free from heterosexist bias, works from the assumption that sexual orientation and gender identity/expression are normal expressions of human sexuality and identity (Kort, 2004).

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Kort, a Michigan social worker specializing in gay-affirmative practice, argues that gay-affirmative services promote self-acceptance of sexual orientation and gender identity/expression (2008). He further states that affirmative practice goes beyond that of simply being tolerant or friendly to LGBTQ issues. Furthermore, it is not even enough for practitioners to be LGBTQ-identified and claim they are affirming toward the community. Affirmative practice means celebrating sexual orientation and gender identity/expression as a form of diversity that adds to the richness of our society (Kort, 2008).

Attempts have also been made in social work to measure LGBTQ-affirmative practice methods. One of the most widely used measures in social work for LGBTQ-affirmative practice is Crisp's (2006) Gay-Affirmative Practice (GAP) scale. Conceptually, GAP in social work views LGBTQ individuals from the person-in-environment perspective and recognizes that LGBTQ individuals have strengths that help them cope with homophobia and heterosexism. Further, GAP emphasizes that cultural competence is necessary in working with LGBTQ individuals, that LGBTQ identities are just as healthy as non-LGBTQ identities, that social workers should help LGBTQ individuals negotiate the challenges of deciding when and if "coming out" makes sense for them individually, and that social workers must engage in raising consciousness about the ongoing and challenging role of homophobia and heterosexism within society.

Crisp's (2006) GAP is a 30-item scale that measures beliefs ($\alpha = 0.93$) and behavioral ($\alpha = 0.94$) intentions of social workers for affirmative and strengths-based practice. Social workers responding to the GAP scale indicate their willingness to support the diverse makeup of LGBTQ families, verbalize respect, educate themselves about LGBTQ communities, and help LGBTQ individuals challenge discrimination and shame about their identity. Additionally, GAP measures social workers' willingness to talk openly about LGBTQ issues, verbalize that LGBTQ identities can be as healthy as heterosexual identities, and create a climate that encourages openness and authenticity around one's LGBTQ identity when suitable for the services being offered.

Available empirical evidence within the social work professional literature shows a trend toward affirming and strength-based practice with LGBTQ communities. Though some recent studies show evidence of negative attitudes toward LGBTQ communities among social workers and students (Kulkin, Williams, Boykin, & Ahn, 2009; Dentato et al., 2016); other studies have shown that social workers have a willingness to engage in affirmative practice (Black, Oles, & Moore, 1998; Dentato, Craig, Messinger, Lloyd, & McInroy, 2014; Logie, Bridge, & Bridge, 2007; Swank & Raiz, 2010). In a study that examined heterosexual psychologists, social workers, and marriage and family therapists ($N = 476$) engagement in affirmative practice, Alessi, Dillon, and Kim (2015) found that training interventions that help practitioners to understand the importance of affirming and strengths-based practice positively affects beliefs and engagement in affirmative practice approaches. Study participants noted that additional training on LGBTQ issues resulted in a stronger willingness and ability to practice affirmatively.

Evidence shows that social work educational settings are giving serious attention to affirming and strengths-based practices. Competency in two of CSWE's (2015) Educational Policy and Accreditation Standards note that social workers should work to understand the importance of diversity, which include both sexual orientation and gender identity/expression, on the formation of human identity. There are an encouraging number of social work faculty who are teaching LGBTQ-affirmative practice within the classroom (Chonody & Smith, 2013; Einbinder, Fiechter,

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Sheridan, & Miller, 2012; Rowntree, 2014; Woodford, Luke, Grogan-Kaylor, Fredriksen-Goldsen, & Gutierrez, 2012). This evidence suggests that LGBTQ-affirmative practice is becoming a norm within some schools of social work.

CONCLUSION

Affirming and strengths-based practice models include a range of safe, supportive practice models that celebrate sexual orientation and gender identity and expression. LGBTQ individuals experience many of the joys and struggles of ordinary human experience yet are challenged by stigma-related experiences that occur in everyday life. Surely, LGBTQ liberation has brought many positive changes for individuals with various sexual orientations and gender identities and expressions. LGBTQ-affirming and strengths-based social workers and practitioners are able to assist individuals and communities to enjoy the rewards of fully participating within society. By recognizing that LGBTQ individuals and communities have a variety of interpersonal strengths and community support systems from which they may draw in times of need, practitioners are able to aid clients in identifying their own resilience and capacity for development.

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