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Building Resilience: Helping Emerging Adults Cope During the Novel Coronavirus Pandemic

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Abstract
The rapid spread of COVID-19 led to, among other things, confusion in news coverage and public health safety. In academe, university leaders were pressured to quickly construct new plans for holding university classes while integrating the safety protocols required by government officials. Though this sudden shift may have been necessary, it also disrupted the biopsychosocial needs, developmental norms, and milestones of emerging adults on college campuses. Current research on emerging adults' biopsychosocial needs during COVID-19 is scant, and research efforts may have been diverted due to the suddenness of campus shutdowns. Social work clinicians nonetheless need a theoretical framework that primarily focuses on emerging adults' needs during and post pandemic. Therapeutic settings create platforms for emerging adults to share their stories and for clinicians to understand their clients' lived experiences during a pandemic such as COVID-19. An awareness of how the experience of shared trauma can affect the therapeutic relationship is crucial to the wellbeing of both client and clinician. This composite case study illustrates a treatment intervention constructed from resilience theory that included narrating what unfolded, learning emotional regulation, building sources of support, and making meaning of the experience. The framework in this paper suggests that resilience theory can be an effective therapeutic approach for emerging adults during and after the COVID-19 pandemic and recommends further attention to the role of social workers in higher education.

Keywords COVID-19 · Emerging adulthood · Resilience theory · Shared trauma · Social work · College campuses

Building Resilience: Helping Emerging Adults Cope During the Novel Coronavirus Pandemic

In March of 2020, the novel coronavirus (COVID-19) spread throughout the United States, profoundly impacting emerging adults (EA) on college campuses (Cohen et al., 2020; Gigliotti, 2020). Rather than the typical EA experience of new challenges in academic rigor, planning weekend festivities with friends, and considering future decisions like traveling abroad, declaring a major, or rushing for Greek life, the COVID-19 pandemic precipitated an abrupt halt in these explorations. During COVID-19, typically robust, active academic environments were rapidly changed (Floyd, 2020) as educational leaders formulated plans to keep students safe and uphold the integrity of university education (Fernandez & Shaw, 2020). Depending on state requirements and school preparedness, plans of action varied; however, the main goal was containment of the rapidly spreading virus (Gigliotti, 2020). Universities took radical steps to "flatten the curve" by abruptly closing residential life and sending students home to complete their semesters virtually (Fernandez & Shaw, 2020; Floyd, 2020). These steps hastily altered key aspects of EAs' lives: how their professors taught, how they connected with peers, and what living on a college campus was like (Floyd, 2020). EAs' feelings of discontent followed these shifts (Bertuccio & Runion, 2020) almost as quickly as COVID-19 flooded the United States. Students navigated a myriad of abrupt changes and feelings while waiting for their universities to decide how to conduct the remainder of the semester.

While minimal research exists on the biopsychosocial impact of COVID-19 on EAs in college (Husky et al., 2020)

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and what it has been like to grieve "life as they knew it," what is clear is that the needs of EAs were overlooked and mental health treatments for this group were an afterthought (Son et al., 2020). This case study considers the needs of EAs navigating their "new normal," explores therapeutic interventions informed by resilience theory, and suggests interventions to offset the long-term ramifications of the COVID-19 pandemic. Resilience theory, a strengths-based theoretical framework, explores why some individuals bounce back after adversity and positively adjust (Van Breda 2018; Zimmerman, 2013). Another concept crucial to successful outcomes is the clinician's awareness of how his or her own experience of a shared trauma, like the COVID-19 pandemic, can enhance or impede progress in developing and maintaining resilience and adaptability (Tosone, 2021).

To thrive and exhibit resilience in the face of life challenges, EAs require a platform to individuate, explore this phase between adolescence and adulthood, and focus on becoming self-reliant (Arnett, 2006). EAs are no strangers to uncertainty and ambiguity; however, with the nature of their routine lives shattered, nothing could have prepared them for the level of devastation caused by the pandemic.

Literature Review

COVID-19

COVID-19 originated in Wuhan, China (Ye et al., 2020), and the first case in the United States was detected on January 19, 2020 (Gigliotti, 2020). Initially, the World Health Organization (2020) deemed the outbreak a Public Health Emergency of International Concern; however, as cases spread across the world, the outbreak was elevated to a pandemic (Gigliotti, 2020). By late November, the Centers for Disease Control and Prevention (2020) estimated that 13.1 million Americans had contracted the virus. COVID-19 has been described as an acute respiratory illness and symptoms include high fever, coughing, shortened, labored breathing, and death (Centers for Disease Control and Prevention, 2020). To mitigate the spread of this deadly virus in the United States, local and state officials devised numerous plans of action (Haffajee & Mello, 2020). At the college level, academic leaders enforced campus lockdowns, required "social distancing" and mask-wearing, contact traced students, and implemented fully remote learning. While these steps were necessary, they hardly considered the effects on EAs' biopsychosocial development.

Emerging Adults and COVID-19 on College Campuses

Most EAs in western cultures delay marriage, pursue higher education, frequently change their living arrangements, and dismantle previously understood developmental benchmarks (Arnett, 2006; Shanahan, 2020). They mature emotionally (Reio & Sanders-Reio, 2020), deepen intimate and platonic relationships, and establish their political ideals (Hochberg & Konner, 2020), as well as their academic and career goals. By age 25, a formal restructuring of the brain occurs: neurons prune, white matter increases (Hochberg & Konner, 2020), and the frontal lobe finishes myelinating. Major developmental shifts occur when EAs move from adolescence to adulthood (Meyer et al., 2019). While Arnett's (2006) work remains at the forefront of the theory of emerging adulthood, Nelson (2020) encourages researchers to explore its current accuracy, applicability, and relatedness to the modern-day EA.

Historically, the college experience enhanced this stage of development (Lane, 2020) through robust campus life, an animated residential experience, in-person and dynamic classes, and opportunities to socialize with peers. Life on college campuses presents many biopsychosocial and academic challenges and an increased exposure to challenging life events (Galatzer-Levy et al., 2012). For many, the pandemic is one of the most difficult life events to date. Academic leaders knew they had to keep students physically safe; however, their precautionary measures hardly considered the magnitude of the impact it would have on EAs. In abruptly closing campuses, canceling commencement celebrations, and moving the remainder of the semester online (Fernandez & Shaw, 2020), administrators left students confused and wondering what the fall semester would look like. As it approached, colleges and universities formulated plans to safely reopen (Roper, 2020). In a survey of 1,000 U.S. colleges conducted by the *Chronicle of Higher Education* of 1,000 U.S. colleges, 53% planned to offer in-person classes for the upcoming fall semester (Roper, 2020). However, this survey did not ask academic leaders what the college experience would be like for EAs walking back on campus.

In 2020, EAs adopted terms of the new normal into their vocabulary: social distancing, contact tracing, mandatory quarantine, and campus lockdown. Unfortunately, these restrictions prevented EAs from behaving in ways that felt inherently and developmentally natural. Studies in numerous international settings, including China, Bangladesh, Switzerland, France, and Greece, revealed the effects of these numerous biopsychosocial disruptions. EAs reported concerns over disruptions to their educational programming (Cao et al., 2020; Islam et al., 2020), funds for schooling (Islam et al., 2020), restrictions on their social life (Elmer et

al., 2020) due to confinement (Husky et al., 2020), as well as increased anxiety (Cao et al., 2020; Islam et al., 2020), depression (Islam et al., 2020), suicidality, and sleeplessness (Kaparounaki et al., 2020). In the United States to date, the only study by the end of 2021 that considered the psychological effects of COVID-19 on EAs found that, of 195 students interviewed from a university in Texas, 71% reported an increase in anxiety due to the pandemic (Son et al., 2020). Partially due to the newness of this world health crisis, research is lacking on how the pandemic disrupted the dynamic facets that nurture EAs' lives.

Social work clinicians who specialize in counseling EAs require an approach to clinical practice that assesses risk and protective factors for EAs throughout the pandemic (Ye et al., 2020). According to Thiessen (1997), enhancing protective factors and decreasing risk factors may lead to positive biopsychosocial outcomes for EAs. (Table 1 contains a summary of risk and protective factors for EAs during COVID-19.) Once these factors are established, clinicians can incorporate a preferred clinical orientation like resilience theory into counseling to help EAs process adversity occurring during the pandemic or any subsequent situation that affects the physical and psychosocial health of a community.

Numerous treatment modalities such as trauma theory, classical grief theory, cognitive behavioral therapy, and narrative therapy can intersect with risk and protective factors.

Table 1 Summary of risk and protective factors of EAs during COVID-19

Risk factors	Protective factors
Social distancing and quarantine requirements which limited peer contact and connectedness	Digital communication with peers
Concern over a relative or loved one being infected with COVID-19	Stable family income
Virtual learning and hybrid models that created disruptions in academic programs	Concrete friend group
Living alone and changes in a living environment	Living with parents
Financial stress and job loss	Living in an urban area
Isolation dormitories	Clear communication from academic leaders
Effect of false positives on the validity of monitoring programs on campuses	Campus preparedness for a crisis
Limited access to professional support or distrust of counseling services	Professors offering a pass/fail option for the semester
Denial of the current circumstances	A healthy outlook and an attitude of acceptance

Note: Summarized from Cao et al., 2020; Cohen et al., 2020; Elmer et al., 2020; Fernandez & Shaw, 2020; Floyd, 2020; Paltiel et al., 2020; Shanahan, et al., 2020; Son et al., 2020; Ye et al., 2020; Zhai & Du, 2020

Previous research examines correlation between risk and protective factors and the development of PTSD, depression, and other mental health concerns (Carlson et al., 2016). In the case at the heart of this article, the prominent, relevant risk and protective factors were social distancing and quarantine requirements, the use of digital communication for virtual learning, the impact of campus preparedness for a crisis, and communication from academic leaders. Identifying risk and protective factors in EAs may be critical to reducing psychological distress during the pandemic (Ye et al., 2020), yet no studies in early 2020 linked how risk and protective factors impact EAs' biopsychosocial development, therefore leaving clinicians without a theoretical approach to draw from (Cao et al., 2020; Ye et al., 2020; Zhai & Du, 2020). This study evaluates risk and protective factors, weaves in the tenets of resilience theory, and proposes what adaptation and stabilization could look like for EAs during the pandemic or other disrupting societal or life events.

Resilience Theory in Practice

From the Latin word *resilire*, meaning "rebound" (Masten, 2014, p. 230), resilience refers to the process of facing hardship, making sense of struggle (Walsh, 2020), and keeping a hopeful perspective. It encapsulates our internal experience of coping, adapting, and emotionally persevering when faced with challenges, psychological distress, or a loss (Norris et al., 2008; Walsh, 2020). As best described by Walsh (2006) and Henderson (2007), we hold the innate capacity to bounce back from adversity but must remain present, active, and committed to this process. Van Breda (2018) explains that mediating factors influence resilience building. These factors include reflecting (Leung et al., 2020), accepting the support of loved ones, garnering emboldening resources, using one's voice to choose and participate in a particular intervention, experiencing cultural and community acceptance (Ungar, 2008), and remaining hopeful (Van Breda, 2018). Social workers are aware of many natural overlays between building resilience and developmental norms of EAs such as accepting the support of friends, personifying individuality, finding one's voice, and seeking creative ways to navigate life.

Sandra Prince-Embury (2014) developed the three-factor model of personal resilience, which seeks to simplify resilience theory and create concepts that are integrable to direct clinical practice. The approach assesses an individual's protective factors: "sense of mastery" and "sense of relatedness," along with the risk factor "emotional reactivity." The first tenet, sense of mastery, examines how an individual solves problems, perceives themselves and their outside world, views their capabilities, and adopts

hopefulness (Prince-Embury et al., 2016). Sense of relatedness explores the collective experience of being human, our biological imperative to connect and experience trust, security, and mutual acceptance of others (Prince-Embury et al., 2016). Emotional reactivity measures "sensitivity, length of recovery time from emotional upset, and impairment or degree of disrupted functioning related to emotional upset" (Prince-Embury et al., 2016, p. 279). These principles lead to the development of the Resiliency Scale for Young Adults (RSYA) (Prince-Embury et al., 2016).

Deficits exist in research on resilience and EAs in college during the pandemic (Ye et al., 2020). One study focusing on individuals ages 18–25 years old revealed that 5% of participants reported an increase in mental health care during the pandemic such as seeing a psychologist, starting psychotropic medication, and receiving care in an inpatient facility (Marchini et al., 2020). Researchers gathered, via online survey, how protective and risk factors of resilience, loneliness, and social and family contact impacted their coping during the pandemic lockdowns (Marchini et al., 2020). Findings revealed that participants who viewed themselves as resilient and had the support of peers were better able to cope (Marchini et al., 2020). However, rather than the RYSA, researchers utilized an adult scale, the RSA, which failed to address the specific traits of this subgroup. Still, these findings suggest that a theoretical framework connecting EAs with mental health resources and sources of support (Marchini et al., 2020) could help EAs adapt to the new normal during COVID-19.

Walsh (2020) explains that individuals healed and built resilience by navigating the effects of the pandemic and adopting a hopeful outlook. Self-righting, a concept first introduced in 1990, considers the innate ability to "put your life back on track" similar "to a capsized boat being restored to an upright position" (Neenan, 2018, p. 8). This process includes making meaning of loss (Park, 2010; Walsh, 2020; Zhai & Du, 2020), practicing self-compassion, shifting one's perspective (Walsh, 2007), keeping an open heart, and accepting the support of others (Walsh, 2020; Ye et al., 2020). EAs in college who sought out clinical help during the pandemic also engaged in an experience of shared trauma that may contribute to their ability to develop resilience.

Role of Shared Trauma

During the pandemic, clinicians and clients simultaneously navigated the same traumatic event. The term shared trauma came into wide use following the September 11th attacks on New York City and "is defined as the affective, behavioral, cognitive, spiritual, and multi-modal responses that clinicians experience as a result of dual exposure to the same collective trauma as their clients" (Tosone et al., 2012, p. 233). Due to the nature of a shared trauma, the therapeutic relationship shifts (Catrone, 2021): clinicians are more vulnerable, boundaries can become blurred, and self-disclosure may increase. Historically, clinicians may have maintained a more conventionally professional demeanor (Tosone et al., 2012); however, during the pandemic clients benefited from a more relational model (Singer, 2020). As clinicians shared their humanity with their clients (Singer, 2020), including their own losses and feelings of uncertainty, a greater therapeutic intimacy was fostered (Tosone et al., 2012).

For many clinicians, providing therapeutic care during 2020 gave them a deep sense of purpose and meaning (Singer, 2020). While many never could have fathomed the effects of the COVID-19 pandemic on their work, those in the counseling profession were asked to remain present with their clients despite their own hardship. In shared trauma, the impact is therefore omnipresent for the clinician (Figley, 2021). During the pandemic, many clinicians struggled to balance their own wellbeing (Singer, 2020) and as is true during all shared traumas, the prioritization of self-care for clinicians was imperative (Tosone et al., 2012). Many clinicians learned during the COVID-19 pandemic that by sharing and learning from one another, clients and clinicians were able to better grasp what was unfolding (Piccolino, 2021) and ultimately develop shared resilience (Nuttman-Shwartz, 2015). Shared resilience is a result of empathetic connection with clients and the ability to make meaning and grasp how the shared trauma facilitated growth for both the clinician and client (Nuttman-Shwartz, 2015). Thus, the clinician and the emerging adult in this case study were both strengthened by the therapeutic relationship.

Methodology

The purpose of this case study is to cultivate a deeper understanding of EAs during the COVID-19 pandemic and create interventions for social work practice. Case study methodology supports researchers in assembling data that highlights their case and informs clinical practice and policy formation (Baxter & Jack, 2008). This case composite encapsulates the internal and external experience of three EAs during COVID-19 and the way treatment, informed by resilience theory, enhanced their adaptation and coping. The concept of shared trauma is highlighted to demonstrate how this phenomenon impacts the therapeutic relationship and treatment outcomes. The following case is a composite of three EAs whose stories have been married into one and slightly altered to protect the privacy and anonymity of my clients.

Case Narrative

Amelia, a 19-year-old cisgender, heterosexual, White female, presented to my practice in early 2020, seeking treatment for generalized anxiety disorder. During the initial intake, she was a senior in high school and pursuing the college application process. Three months into treatment, COVID-19 spread and her state governor enacted an executive order to close schools indefinitely. Around this time, Amelia secured admission to a prestigious university in the Midwest and planned to major in musical theater. As late spring and early summer approached, our sessions fluctuated between excitement and uncertainty around what her fall semester would look like due to COVID-19.

Amelia's university delayed opening by two weeks and required that students provide a negative COVID test result prior to entering campus. Her parents opted to stay at a local hotel to ease her first week at school, knowing that a lack of social support could impede her capacity to feel ready for life in academia (Florence & Rosser, 2018). Amelia felt tenuous about staying, unsure if she could handle the nature of virtual classes and campus restrictions. She contemplated leaving with her parents. Ultimately Amelia decided she wanted to be at school and persevere. Although her college world felt uncertain, our weekly sessions offered a predictable touchstone to process her experiences.

While college is challenging and creates hurdles for every EA (Nelson, 2020), no level of preparedness could have equipped Amelia for what would unfold at her university. Because I knew that Amelia had struggled with anxiety in the past and that the ambiguity she was facing could exacerbate her condition (Gu et al., 2020), we created a plan to help her navigate the fall semester. During our sessions we reflected on how COVID-19 could affect her, examined its effect on building friendships, and resolved to prioritize her mental health throughout. I explained to Amelia that the word resilience refers to getting through the grit and could be an anchoring word or mantra for when moments felt hard. She appreciated this and voiced a desire to remain present and committed to her process during the good moments and despite the bad ones.

Emotional Reactivity: Amelia and COVID-19

To enhance Amelia's adaptation and coping during her sessions, I kept the properties of resilience theory at the forefront of my mind. I prioritized her narrating without adding commentary to prevent Amelia from internalizing the challenges of her current reality and the associated emotions. During her first weeks at school, she shared frustrations about campus restrictions: "I have to get tested weekly, my university shut down an entire dorm because of positive cases, and I have to rush for Greek life over Zoom." As she spoke, I monitored her somatic cues or body responses that indicate shifts in emotionality (Price & Hooven, 2018). I noticed her eyes watering and breath shortening and remarked, "This must all be so tough for you." Amelia's head sank, and she nodded. I sensed from this body language that she felt defeated. I voiced my hope to help her return to a more balanced state by integrating a self-regulating skill (Price & Hooven, 2018) called "self holding," an exercise that allows us to appreciate our body as a container that holds challenging moments and associated emotions (Levine, 2013).

Curious about the exercise, Amelia sat up straighter and gazed more intently through her computer screen. Demonstrating the exercise to guide her, I asked her to place one hand under the opposite arm and then place the other hand over the other arm's upper part, giving herself a hug. I invited her to close her eyes and tune into her breathing. I paused, taking in the magnitude of this moment; amid the pandemic and over a computer screen, my 19-year-old client displayed reverence and commitment to her therapeutic process. I offered my words of support, saying, "This *is* hard, and your experience is so valid. Can you allow yourself to feel supported and your emotions to feel contained?" Amelia breathed deeply, allowing herself to settle. Her shoulders relaxed and her facial expressions softened. Minutes later, she opened her eyes, returned to our session, and expressed feeling calmer and more present. I explained to Amelia that part of our therapeutic work is measuring her emotional reactivity, that is, how well she returns to a grounded state after a distressing event. She laughed lightly, stating, "I've always needed to manage my emotions better, but because of the pandemic things feel even more intense than ever before." Throughout our sessions, Amelia and I worked to monitor her emotional reactivity and implemented self holding when needed.

Sense of Relatedness and COVID Socializing

At the following session, Amelia voiced wariness about the president of her university, vehemently sharing, "Cases on campus rose and 600 students tested positive; large gatherings at the sororities and fraternities are to blame. It's annoying; the president studied epidemics and had every opportunity to put things in place. We are all suffering because of his negligence. I can't even go outside." Her university enforced a 14-day campus-wide shut down. Students could not leave their dorm or campus except for groceries or medical attention. In-person classes became remote, and ancillary buildings were closed. During the pandemic, clear and concise communication from some academic leaders increased many students' trust (Fernandez & Shaw, 2020). For Amelia, this piece of building trust was missing.

I felt powerless as, over a computer screen, I watched her brow furrow and expressions of sadness and frustration move over her face. I held space for her current, challenging reality and accepted how few solutions existed to resolve these actualities. During this session, I weighed the effectiveness of self-disclosure, a powerful intervention that can further feelings of support and understanding within the therapeutic relationship (Warrender, 2020). With Amelia's permission, I shared, "I feel so helpless in this moment, unsure what direction to go to best help you. I so badly wish I could make this all better for you and that your freshman year was more of what you hoped it would be." She paused, looked through her screen at me and said, "Me too." Our session allowed for an exchange of humanness, or sense of relatedness, and acknowledgment of how immobilized COVID-19 had us both feeling. In essence, Amelia and I were experiencing a shared trauma; we were entangled in the same life altering and traumatic event (Figley, 2021; Holmes et al., 2021).

Through this process with Amelia, I became aware of our mutuality: my experience of the pandemic was influenced by hers and vice versa; while our relationship was professional, it had also become personal (Tosone et al., 2012) As clinicians, it's exceedingly rare that we navigate the same trauma alongside our clients. Even when I may have a memory of similar experiences in my life, this experience was different. My exchange with Amelia was transformative, and what I came to realize was that my sense of self served as an intervention and tool in Amelia's care.

While I worried about the effects of my self-disclosure and blurring of professional boundaries (Tosone et al., 2012), I knew that with shared trauma there is also the possibility of shared resilience (Figley, 2021). Part of building resiliency is truly being present in a moment with another, experiencing trust and total understanding of another's emotions. Our conversation paved the way for a deeper discussion about how our interaction accurately depicted our circumstances outside of session. It fostered a greater reflection about personal responsibility and coping. We agreed that embracing a hopeful perspective, another effective paradigm of resilience theory (Buikstra et al., 2010), would help Amelia view her current challenges as changeable and temporary.

That evening, I reflected on my session with Amelia and jotted down a few notes in my 2020 journal, a practice I started early in the pandemic as I knew future me would want to remember how events unfolded that year. The entry from that evening states, "How is it that I am supposed to duly hold space, be strong, and offer support when life itself feels so messy and uncertain for me? Is simply *being there* enough?" Like many of my clinician colleagues in 2020, I struggled with caring for my patients while simultaneously navigating the effects of the pandemic on myself, including my own prolonged trauma, loss, and uncertainty. Through this process with Amelia, I realized that, just as I was a touchstone for her, she had become a touchstone for me. My work with Amelia also gave me a deep sense of purpose throughout the pandemic (Singer, 2020) and carried me through some of my darkest moments of 2020.

Shortly after this session, the campus-wide lockdown lifted, and, unfortunately, Amelia contracted COVID. She faced two options: go home or quarantine at the COVID dorm. She felt frustrated, knowing how careful she had been with social distancing efforts. To reduce her emotional reactivity and enhance her problem-solving skills, we created a list of pros and cons weighing the options of quarantining at school versus at home for two weeks. The cons list—abysmal dorm conditions, no social contact, only packaged food items to eat, and restrictions on leaving the building until testing negative for COVID twice—exceeded the pros list. Ultimately, Amelia decided to go home. During this time, she had grown closer with her roommate Kate. Initially, she feared being shamed or judged for contracting COVID, a common experience that leads to harmful self-criticism (Cavalera, 2020). Instead, Amelia grew hopeful and stated, "I know this is temporary and I am grateful I have Kate." In Amelia's session that week, I shared my observations, "I notice you tactically applied some principles of resilience theory to cope during your quarantine. You remained present, hopeful, and allowed your friendship with Kate to alleviate the effects of the quarantine." She smiled sharing that she too noticed the shifts. I noted in my mind that Amelia was successfully attending to her developmental needs while simultaneously building resiliency.

For all of us, social distancing requirements significantly disrupted how we connect in relationships (Abel & McQueen, 2020). Strong friendships are predictors of happiness in EAs (Demir, 2010) and are one of the most important parts of building resilience. For Amelia, this was a critical part of what college was about: making new friends and finding *her* people. With this goal in mind, we coined the term "COVID socializing" to acknowledge the imperativeness of building relationships while ensuring her health safety and that of others. We created weekly tasks that fostered relationship building while honoring COVID-19 safety protocol.

Now that Amelia was back on campus, her first task involved putting her Snapchat handle on her dorm room door. During COVID-19, social media has been identified as an important means of remaining connected with friends, reducing boredom, and offsetting any negative psychological impacts of isolation (González-Padilla & Tortolero-Blanco, 2020). The Snapchat task led to Amelia and Kate meeting Jen, a peer who lived on the same floor but was without a roommate. The three girls quickly bonded, and

although it did not constitute a large friend group, Amelia felt grateful for their closeness. Building supportive relationships, a fundamental principle of resilience theory and a distinctive trait of EAs (Masten, 2014; Ungar, 2008) is established by emoting with peers and leaning on another during adverse life events. We processed in therapy what it meant to have two new meaningful friendships versus a large friend group; Amelia reflected, "Many people don't have a friend group because of the nature of what is going on. I don't think it is weird that I don't either. It's comforting to know that *everyone* is going through the same thing." For Amelia, it was an unspoken sense of universality in her experience that brought her a deep sense of comfort.

Sense of Mastery and Meaning Making

While she was home in December, Amelia and I reflected on what transpired during her fall semester. She voiced a desire to look back at 2020 as a year *not* wasted. I integrated meaning making and hoped that Amelia would grasp the significance of everything she overcame and take away some powerful life lessons. Meaning making encompasses "making sense" of or being able to understand an experience differently and find the benefit or positives that came from it (Coleman & Neimeyer, 2010, p. 804). As Amelia considered the version of herself that stepped onto campus versus herself at the present day, she half-smiled and shook her head, stating, "I am not that same person." Amelia recognized that her past self felt sad, anxious, uncertain, and confused. However, by focusing on new friendships, navigating COVID-19, and adjusting to her circumstances, she successfully completed her fall semester and took away some positive lessons and a sense of mastery (Prince-Embury, 2014). I then felt my own sense of tremendous pride for Amelia. Not only had she overcome numerous hurdles, but she had also grown more emotionally mature and developed a very resilient outlook.

We continued to explore how these themes could carry into the next semester and what life would look like in the spring. Instead of worrying what may be, she voiced a desire to focus on the here and now: "Life won't be consistent all the time; however, I am more capable of handling what may come. I am home until late January and I know what campus life will look like when I return."

Discussion

My work with Amelia reflects the necessity for clinical approaches that address emerging adult needs during a pandemic. Before this case study, research was devoid of a theoretical framework clinicians could implement while working with cases like Amelia's. As a clinician specializing in emerging adults, I hypothesized that EAs on college campuses were in dire need of mental health support during and post pandemic. When determining my interventions, I considered Amelia's developmental norms, the limitations set by her campus restrictions, and the lasting effects of COVID-19. In the throes of the pandemic, I anticipated that long term, many EAs could walk away from this chapter gravely impacted by the experiences they endured. I used practice wisdom and my clinical experience to implement resilience theory, knowing that it complements the developmental norms of emerging adults. In Amelia's case, therapy was successful because it included a model of care that was flexible and could be adjusted based on the latest changes occurring with the pandemic. Amelia completed her freshman year, developed friendships, and retained an adaptable attitude about COVID.

While Amelia's treatment outcomes were favorable, this case study has its limitations. For one thing, case studies are limited by nature and tend to encapsulate only one demographic (Baxter & Jack, 2008). Second, like Amelia, many college EAs were negatively impacted by life-altering factors of the pandemic, such as the death of a loved one and disruptions to their college experience. Critically, however, Amelia's case represents a single gender and race and a privileged group with resources to access therapeutic care. It does not include more oppressed, marginalized, and disenfranchised groups for whom COVID-19 created increased risk. Indeed, the pandemic further exposed what researchers already knew–that public health crises disproportionately harm people of certain ethnic and racial groups already navigating "the toxic stress of poverty, crime, unemployment, racism, and discrimination" (Fortuna et al., 2020, p. 443). Amelia had the resources to receive therapy during the pandemic, whereas many EAs did not. As a result, some EAs may be at risk to develop PTSD, complex grief, and social anxiety due to isolation. Future research might explore how college counseling centers can assess and aid at-risk students with interventions such as eye movement desensitization and reprocessing (EMDR), autoethnography, cognitive behavioral therapy, and narrative therapy to reduce symptomatology caused by the pandemic.

Furthermore, the pandemic necessitated the use of digital communication (Robbins et al., 2020) for all college EAs, but EAs from marginalized groups may lack access to technology and counseling services, impacting both their ability to attend classes virtually and to receive virtual mental health treatment. Current research confirms that many colleges EAs struggled with online and remote connection, resulting in increases in anxiety, depression, and low self-esteem (Rajkumar, 2020), especially among marginalized groups. Future research should focus on treatment

interventions that address the rise in technology use among all EAs during the pandemic (Haddad et al., 2021) but especially among EAs from oppressed groups. Moreover, as of this writing, EAs have returned to campuses for the 2021–22 school year. Those in social work and higher education need to hear what the experiences are like for EAs currently on campuses.

The private sector leaves room for improvement too. Clinicians could offer therapy at a reduced session rate to EAs in more marginalized and disenfranchised groups who lack the means to access therapy. It is crucial that future research delve into the experiences of this group and social workers use their voices to advocate for marginalized EAs at continuing education trainings and speaking engagements. Finally, the notion of shared trauma during and post COVID-19 requires ongoing attention in the form of qualitative and longitudinal research to understand the experience of clinicians who provided care to EAs during this time. Perhaps as significant for further growth of our profession is the need for systematic investigation for counseling responses in a time of shared trauma. Indeed, the concept and awareness of shared trauma needs to be further explored. As our societies increasingly experience shared traumas, the ethical implications around personal self-disclosure and transference must be reexamined and incorporated into the ethical standards of the profession. Researchers might examine how clinicians coped and practiced self-care during the pandemic while experiencing a shared trauma with their clients.

Because we can now imagine another event like the pandemic, and we now understand that the effects of the pandemic are ongoing, social work clinicians would benefit from research in key areas: development of interventions and therapeutic tools that address EAs from disenfranchised groups, issues of social justice, and the developmental norms of EAs. Social work clinicians might integrate questions into their psychiatric evaluations and develop screening tools designed to assess the effects of the pandemic. Research like this could therefore guide longitudinal studies to assess the long-term effects of COVID-19 (Shanahan et al., 2020) and influence future interventions.

Conclusion

During COVID-19, EAs like Amelia required a treatment approach that considered their biopsychosocial needs. Post COVID-19, research needs to explore and give voice not only to Amelia, but also to a broader swath of EAs from more marginalized, disenfranchised, and less affluent groups to aid clinical social workers, academic leaders, and future scholars in their work. Amelia's experience intersects with other phenomena like grief, loss, and trauma caused by the death of loved ones, financial hardship, and the sudden shifts to fully remote semesters. The implications of this study also extend to the role of social workers in higher education. Universities need social workers to continue to assess EA needs on college campuses because the pandemic is ongoing. One important way to address this is to invite clinicians onto college campuses, not just to the counseling department but also to the table where policies and procedures are made for EAs. Understanding the impact of shared trauma will be crucial in these interactions. Amelia's story is layered with vulnerability, uncertainty, developmental disruption, coping, and resilience building. Her experience offers an opportunity to reflect on ways emerging adults going through prolonged adversity could arrive on the other side of their journey stronger and more resilient than when they began.

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