

# Therapy, less screen time and 'changing playgrounds' helped one young Utahn improve her mental health

This is part of a series of interviews with young Utahns making a meaningful impact on their communities — and their own — mental health. To protect their privacy, participants under 18 are identified only by their first names. Read more at [sltrib.com](https://sltrib.com).

**Editor's note** » This article discusses suicide. If you or people you know are at risk of self-harm, call or text 988 to reach the Suicide & Crisis Lifeline for 24-hour support.

Amelia says she was always known as the happy, bright kid. As she got older, though, a pandemic and academic pressure started to weigh on her, even as she worked for her school's Hope Squad, a peer-to-peer suicide prevention group that teaches students how to advocate for themselves and their fellow students.

"I talked to a lot of people about how they were feeling," Amelia told me in a recent interview. "But I didn't ever take the time to make sure that I was ok, I wasn't taking care of myself enough to be taking care of others."

When a former teacher, Elysia Butler, reached out and asked Amelia to join another mental health organization, The Hope Hero Foundation, and help reach other young Utahns via social media, Amelia said she was eager to help.

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ever has been, so I'm kind of using that to my advantage."

She spoke with The Tribune about how her mental health and the loss of a friend prompted her to help others. This Q&A with her has been edited for length and clarity.

**Sara Weber: What drew you to mental health work?**

**Amelia:** I'm a very emotionally in-tune person. I've always been very anxious, and I've gone to therapy since I was very young. So I feel personally connected. I've also had family and friends that have also had mental struggles. One of my friends, at the beginning of sophomore year, took his own life.

**I'm so sorry, that must have been really difficult. How have you cared for your own mental health amid all that?**

When I was in her class, Mrs. Butler would always say, "It's okay to change playgrounds." And what she means by that is you don't have to be friends with the same people all the time. And when my mental health struggles started being a little bit more apparent my sophomore year, I was hanging out around people that didn't really seem to care about me at all. I was like, "Wait, I can just go find another playground." I started expanding who I was hanging out with. I ended up finding a friend group that really cared about me and was interested in who I was.

Another thing that really helped me as I started going to therapy more consistently,

I understand that's not the most accessible thing ever because it is a time and money commitment, but it was very helpful to have an unbiased, professional person to connect with.

The third big one that I've noticed connects to lowering my screen time and spending more time doing the things I love.

**Because you work with social media now, I'm curious: What are your thoughts on the role social media plays in mental health? Is it a tool? A hindrance?**

I think it can be both. The way that I was using my phone and social media was a lot less conscious than I wanted it to be. My average daily screen time a year ago was seven hours. And the average high schooler now is eight-and-a-half hours a day, which is a lot. Then my word for the year was "intention." So I've been more conscious, and my daily screen time now is about an hour, which is a big difference. I feel so much better.

**What advice do you have for other young Utahns who are looking to help improve their peers' mental health?**

Start small. Wave at somebody in the hall that you don't wave at normally. I like to comment on people's Instagram posts that I've never spoken to before. And hopefully it turns into a friendship. Just start with making connections. Connections are easy to make, but they make the biggest difference ever.

## I've seen the rise in colon cancer. As doctors, we must take young people more seriously.

It was movie night on a Friday in the summer of 2020 when my phone rang.

I had been watching "Black Panther" with my son when one of my friends called to see if I had heard the news about actor Chadwick Boseman. With a sense of foreboding, I asked what he meant. After a pregnant pause, he responded: "Mark, he died."

And the reason my friend was calling me — a gastrointestinal oncologist — was that the cause of death was colon cancer.

I started in disbelief at the screen where I had paused the movie, and where Chadwick Boseman was frozen, literally portraying a superhero.

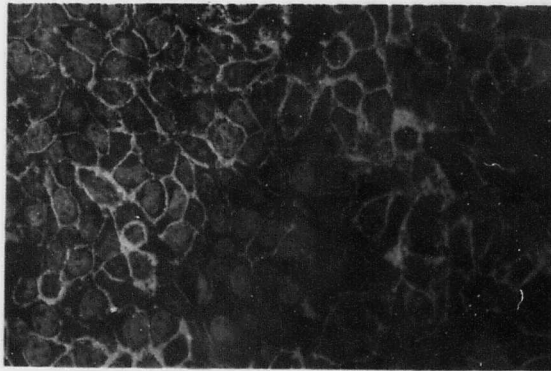
Even with a newly clinical eye, I could only perceive a fit actor at the peak of his powers. It was hard to imagine that he was in anything other than perfect health.

And yet there was part of me that could make sense of this cognitive dissonance, because in my professional life I had been taking care of younger and younger patients with the same cancer type.

This troubling rise in cases is sometimes described as a "birth cohort effect," which means that patients born in 1990 have double the risk of colon cancer (and quadruple the risk of rectal cancer) versus what patients born in 1950 faced at a comparable age.

Colorectal cancer is now the number one cause of cancer death among young men and the second leading cause among young women (defined as no older than 49).

There is a common misconception that cancer is solely a result of getting older. While it is true that cellular senescence is the driver of aging, cancer is almost precisely the opposite, perhaps the closest we can come to immortality on a microscopic scale: cells that can divide indefinitely.



A microscope image shows human colon cancer cells with the nuclei stained red. (NCI CENTER FOR CANCER RESEARCH)

In fact, the very lack of growth inhibition is a hallmark of cancer. So why is this happening? In his book, "The Gene," author Siddhartha Mukherjee proposed this formula summing the causes of any disease, including cancer: heredity + environment + triggers + chance.

Looking at the component parts of that formula, we estimate that up to a quarter of early-onset cases can be attributed to inherited risk, e.g. syndromes that can be transmitted from generation to generation like familial adenomatous polyposis (FAP) or hereditary non-polyposis colorectal cancer (more commonly known as Lynch syndrome).

But that still leaves most cases to be explained by other causes,

which we often refer to as "sporadic" because they occur in the absence of a pathogenic family history.

One way of conceiving this acquired risk is the "exposome," which in colorectal cancer aims to measure the biologic effect of everything that passes through the gut during our lifetime, ranging from foods to antibiotics.

Nutritional epidemiology — the effect of diet on diseases at the level of entire populations — is notoriously difficult to study but some researchers have suggested that the high-temperature preparation of red meat can generate carcinogens like heterocyclic amines and polycyclic aromatic hydrocarbons.

A study within the National

Health Service in the United Kingdom suggested that young-onset colorectal cancer patients were more likely to have been prescribed antibiotics in childhood, presumably then changing the bacteria within their intestinal microbiome to favor carcinogenesis.

Partly in response to this shifting demography, the United States Preventive Services Task Force — the government body most responsible for issuing screening recommendations — in 2021 lowered the age of first screening for colorectal cancer for average-risk individuals from 50 to 45.

While at-home fecal testing is increasingly prevalent, the gold standard for screening

likely remains colonoscopy, because during that procedure doctors — typically gastroenterologists or surgeons — don't just identify pre-cancerous polyps but can remove them, interrupting what we call the adenoma-to-carcinoma sequence. Put another way, a polyp that is completely removed during colonoscopy no longer has the chance to invade and grow into a true cancer.

And yet, even this earlier screening may not be enough to "catch" some patients' colorectal cancer.

Just over 70% of young-onset cases are stage III (locally advanced) or stage IV (metastatic) at the time of diagnosis, and such frequently require chemotherapy.

As recently as this spring, Melissa Inouye — a religious scholar and historian for the Church of Jesus Christ of Latter-Day Saints — died at age 44 of metastatic colon cancer, initially diagnosed when she was 37 and, as she wrote with near-disbelief in one of her books, otherwise in terrific shape, running marathons and eating organic produce she grew in her own garden.

Tragic cases like Chadwick Boseman and Melissa Inouye's are a call to action, to take young patients' gastrointestinal concerns (especially bleeding but also changes in bathroom habits like narrower stools and pain on defecation, or even unintentional weight loss) more seriously.

Screening is different than diagnosis, and any symptomatic patient at any age should merit medical attention.

**Mark Lewis, MD,** is the director of gastrointestinal oncology at Intermountain Health.

## Homeless

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We must start by making a clear distinction between the situational and chronic homelessness which affects Utahns. Not everyone who experiences homelessness falls clearly in one or the other of these categories, and may be somewhere in the middle, but understanding the core differences helps explain the need for unique approaches tailored to each person.

Situational homelessness typically results from sudden, significant life setbacks and can often be alleviated through interventions that include housing and supportive social services. The vast majority of Utahns accessing homeless services fall in this category, and we have great success in supporting their needs. Investments in affordable and deeply affordable housing since 2022 have created over 1,600 units statewide, which is a testament to the vision of our state leaders.

But for those facing chronic homelessness, traditional housing and services alone are not

enough to help them recover housing stability and reintegrate into society. By maintaining a know-by-name system for the roughly 2,300 chronically homeless for whom this term applies, we can provide individualized care plans to help our most vulnerable heal and improve.

Utah needs a robust system of personalized care, with services and supportive housing, to properly address the crisis of chronic homelessness — resources that require deeper investments in proven solutions.

Our goal must be to create systems of support that propel individuals along the continuum of care, starting from street living to the ultimate goal of fostering human dignity. To do so, we have to understand that the core difficulty for those who are chronically homeless is trauma.

When our attention remains solely on the crisis and its demands on the emergency response system, resources tend to be channeled into crisis management rather than nurturing initiatives aimed at preventing homelessness or fostering healing and growth within subpopulations. Recognizing and addressing the pervasive

traumas experienced by chronically homeless Utahns is pivotal in developing effective and compassionate solutions.

To truly help those in the greatest need, we must enhance human dignity, not just provide temporary shelter. This involves investing in deeply affordable and supportive housing, comprehensive wraparound services that support lasting wellbeing and stabilization — such services should address mental and behavioral health, help overcome substance use disorders, improve access to education and employment opportunities, foster connection to community and elevate individual confidence and capability.

Among our many existing shelter sites, we must ensure safe environments that advance stability and improvement, away from criminal exploitation. It is crucial to align our systems to promote responsibility and accountability, fostering an environment that supports resiliency and growth.

Individuals experiencing homelessness aspire to improve their lives and contribute to thriving, supportive communities. The spaces

we construct for those currently facing chronic homelessness must be intentional and purposeful, distinct from those designed for individuals experiencing situational homelessness. For those who have suffered trauma and the ongoing deprivation of human dignity, we cannot expect them to "pull themselves up by their bootstraps" — first, they must be given boots before they are set along the path toward recovery. By understanding the unique needs of each individual, we begin to tailor our crisis response to offer care that addresses the root causes of trauma. Fortunately, these objectives are captured in Utah's Plan to Address Homelessness, which provides a unified, statewide strategic vision.

In this spirit, the Utah Homeless Services Board begins its work.

**Randy Shumway** is the first chair of the Utah Homeless Services Board. **Wayne Nielsen** is Utah's State Homeless Coordinator. **Erin J. Mendenhall** is the 34th mayor of Salt Lake City. **Spencer P. Eccles** is managing partner and co-founder of The Cynsure Group.

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