Look. Listen. Feel.

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With its 2010 Guidelines for Cardiopulmonary Resuscitation (CPR) and Emergency Cardiovascular Care (ECC), the American Heart Association removed its direction that first responders "look, listen, and feel for breathing."[1] Many of us in the healthcare field internalized these words during Basic Life Support (BLS) re-certification trainings. Yet, despite its persistent absence from the current official guidelines, I continue to consider this pithy phrase a tenant of assessment. It directs us be deliberate and attend to our multiple senses to increase our openness to and awareness of stimuli (internal and external)—all with the goal of facilitating and improving assessment. In this manner, the phrase is indeed "basic" (i.e., fundamental) and possesses vast utility and generalizability. Already recognized by some[2] is the extension of this adage to the practice of reflection, and it is with this in mind that I invoke "look, listen, and feel" in reference to the diverse articles in this issue of *Connect*.

In "Psychiatrists Should Be Mental HEALTH Professionals" (p. 6), the second installment of his "Lab to Smartphone" column, Rettew encourages us to reflect upon our identities as child and adolescent psychiatrists. He advocates that we not just limit our professional scope to understanding psychiatric pathology and restoring mental health, but that we also deliberately and proactively attend to an understanding of mental health and wellbeing and how best to preserve them—both for our patients and ourselves, as healthcare providers. Our society's expanding interest in wellness is perhaps underscored by the recent announcement that, this past January, almost a quarter of the entire undergraduate student body at Yale (almost 1,200 undergraduate students) enrolled in a single course titled, "Psychology and the Good Life." As described by *The New York Times*, this course "tries to teach students how to lead a happier, more satisfying life in twice-weekly lectures."[3]

With the opioid epidemic crippling our country, opioid use disorders and, more broadly, substance use disorders, have exploded into our field's consciousness. The review of medication-assisted treatment of substance use disorders among adolescents by Resczenski and Whitmore (p. 10) presents multiple ways by which we can move from awareness and recognition of the problem to the provision of pharmacological intervention—preferably in combination with psychosocial interventions to optimize comprehensive treatment.

The remaining three articles in this issue of *Connect* address topics that are likely less in the forefront of mental health providers' minds and, as such, warrant additional looking, listening, and feeling—particularly through introspection and a challenging of potential assumptions. Cunningham and Brewerton (p. 15) ask us to recognize "too much of a good thing" in the form of pathological exercise (PE)—an entity that can present as a symptom of an eating disorder or body dysmorphic disorder but, importantly, also can exist as an independent primary condition in which an individual's relationship with exercise negatively impacts that individual's physical and mental wellbeing. They point out that, given the frequency with which children and adolescents engage in sports, it is important that clinicians working with youth consider and recognize PE in this population. Raj (p. 21) reviews the topic of domestic minor sex trafficking. In his article, he shares that the vast majority of survivors of domestic sex trafficking report having had some form of contact with a healthcare provider in the preceding year while being trafficked, and he reviews some of the challenges that healthcare providers face in identifying these exploited youth. He emphasizes the mental health needs that this population frequently has both prior to and as a result of sex trafficking. Finally, Pawlowski discusses bullying in the workplace—more specifically, bullying in medicine, and, most specifically, bullying in psychiatric residency training. She encour-

ages us to acknowledge the data that show that our field of psychiatry is not immune to bullying behavior, and to consider our roles in both recognizing bullying and helping shift our culture in psychiatric medicine to better ensure that bullying does not occur among colleagues, including with or among our trainees.

Having entered my final calendar year as editor of *JAACAP Connect*, I am pausing more often to look, listen, and feel. I am grateful for the opportunities that my *Connect* role affords—namely, the chance to work with authors to bring their ideas and experience to publication and, in so doing, the chance to increase action and awareness around various clinical and professional issues affecting our field.

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