“Normally, when we get these calls,” he said, “it’s because some adult the child has contact with is sexually abusing him, and then the kid reenacts it on another kid, like his little brother. But we did a thorough investigation and there was no evidence the older brother was being abused. His parents were divorced and worked a lot, so the kids were kind of raising themselves, but there was no active sexual abuse going on.

“What eventually came out in this case was the older brother had been watching cartoons on the Internet and stumbled across some Japanese anime cartoon showing all kinds of sex acts. The kid had his own iPad, and no one was policing what he was doing, and after watching a bunch of these cartoons, he decided to try it out on his little brother. Now, that kind of thing, in more than twenty years of police work, I’ve never seen before.”

The Internet promotes compulsive overconsumption not merely by providing increased access to drugs old and new, but also by suggesting behaviors that otherwise may never have occurred to us. Videos don’t just “go viral.” They’re literally contagious, hence the advent of the meme.

Human beings are social animals. When we see others behaving in a certain way online, those behaviors seem “normal” because other people are doing them. “Twitter” is an apt name for the social media messaging platform favored by pundits and presidents alike. We are like flocks of birds. No sooner has one of us raised a wing in flight than the entire flock of us is rising into the air.

Jacob looked down at his hands. He couldn’t meet my eyes.

“Then I meet a lady in this chat room. She like to dominate men. I introduce her into the electrical stuff, and then I give her the ability to control the electricity remotely: frequency, volume, structure of the pulses. She likes to bring me to the edge, and then let me not go over. She does this ten times, and other people watch, and make comments. We develop the friendship, this lady and I. She never wants to show her face. But I saw her once, by accident, when her camera fell for a moment.”

“How old was she?” I asked.

“In her forties, I guess . . .”

I wanted to ask what she looked like but sensed my own prurient curiosity at play here, rather than his therapeutic needs, so I refrained.

Jacob said, “My wife discover all this, and she say she will leave me. I promise to stop. I tell my lady friend online I am quitting. My lady friend very angry. My wife very angry. I hate myself then. I stop for a while. Maybe a month. But then I start up again. Just me and my machine, not the chat rooms. I lie to my wife, but eventually she discover. Her therapist tell her to leave me. So my wife, she leave me. She move to our house in Seattle, and now I am alone.”

Shaking his head, he said, “It never as good as I imagine. The reality always less. I tell myself never again, and I destroy the machine and throw it away. But at four a.m. the next morning, I am getting it from the trash and building it again.”

Jacob looked at me with pleading eyes. “I want to stop. I want to. I don’t want to die an addict.”

I’m not sure what to say. I imagine him attached by his genitals through the Internet to a room full of strangers. I feel horror, compassion, and a vague and disquieting sense that it could have been me.

Not unlike Jacob, we are all at risk of titillating ourselves to death.

Seventy percent of world global deaths are attributable to modifiable behavioral risk factors like smoking, physical inactivity, and diet. The leading global risks for mortality are high blood pressure (13 percent), tobacco use (9 percent), high blood sugar (6 percent), physical inactivity (6 percent), and obesity (5 percent). In 2013, an estimated 2.1 billion adults were overweight, compared with 857 million in 1980. There are now more people worldwide, except in parts of sub-Saharan Africa and Asia, who are obese than who are underweight.

Rates of addiction are rising the world over. The disease burden attributed to alcohol and illicit drug addiction is 1.5 percent globally, and more than 5 percent in the United States. These data exclude tobacco consumption.

Drug of choice varies by country. The US is dominated by illicit drugs, Russia and Eastern Europe by alcohol addiction.

Global deaths from addiction have risen in all age groups between 1990 and 2017, with more than half the deaths occurring in people younger than fifty years of age.

The poor and undereducated, especially those living in rich nations, are most susceptible to the problem of compulsive overconsumption. They have easy access to high-reward, high-potency, high-novelty drugs at the same time that they lack access to meaningful work, safe housing, quality education, affordable health care, and race and class equality before the law. This creates a dangerous nexus of addiction risk.

Princeton economists Anne Case and Angus Deaton have shown that middle-aged white Americans without a college degree are dying younger than their parents, grandparents, and great-grandparents. The top three leading causes of death in this group are drug overdoses, alcohol-related liver disease, and suicides. Case and Deaton have aptly called this phenomenon “deaths of despair.”

Our compulsive overconsumption risks not just our demise but also that of our planet. The world’s natural resources are rapidly diminishing. Economists estimate that in 2040 the world’s natural capital (land, forests, fisheries, fuels) will be 21 percent less in high-income countries and 17 percent less in poorer countries than today. Meanwhile, carbon emissions will grow by 7 percent in high-income countries and 44 percent in the rest of the world.

We are devouring ourselves.

CHAPTER 2

Running from Pain

I met David in 2018. He was physically unremarkable: white, medium build, brown hair. He had an uncertainty about him that made him seem younger than the thirty-five years documented in the medical record. I found myself thinking, *He won't last. He'll come back to clinic once or twice and I'll never see him again.*

But I've learned my powers of prognostication are unreliable. I've had patients I was convinced I could help who proved to be intractable, and others I deemed hopeless who were surprisingly resilient. Hence, when seeing new patients now, I try to quiet that doubting voice and remember that everyone's got a shot at recovery.

"Tell me what brings you in," I said.

David's problems began in college, but more precisely the day he walked into student mental health services. He was a twenty-year-old sophomore undergraduate in upstate New York looking for help with anxiety and poor school performance.

His anxiety was triggered by interacting with strangers, or anyone he didn't know well. His face would flush, his chest and back would get damp, and his thoughts would get jumbled. He avoided classes where he had to speak in front of others. He dropped out of a required speech and communications seminar twice, eventually fulfilling the requirement by taking an equivalent class at community college.

"What were you afraid of?" I asked.

“I was afraid to fail. I was afraid to be exposed as not knowing. I was afraid to ask for help.”

After a forty-five-minute appointment and a pencil-and-paper test that took less than five minutes to complete, he was diagnosed with attention deficit disorder (ADD) and generalized anxiety disorder (GAD). The psychologist who administered the test recommended he follow up with a psychiatrist to prescribe an antianxiety medication and, David said, a “stimulant for my ADD.” He was not offered psychotherapy or other nonmedication behavioral modification.

David went to see a psychiatrist, who prescribed Paxil, a selective serotonin reuptake inhibitor to treat depression and anxiety, and Adderall, a stimulant to treat ADD.

“So how did it go for you—the meds, I mean?”

“The Paxil helped with the anxiety a little at first. It dampened down some of the worst sweating, but it wasn’t a cure. I ended up changing my major from computer engineering to computer science, thinking that would help. It required less interaction.

“But because I wasn’t able to speak up and say I didn’t know, I failed an exam. Then I failed the next one. Then I dropped out for a semester not to take a hit on my grade point average. Eventually, I switched out of the school of engineering altogether, which was really sad because it was what I loved and really wanted to do. I became a history major: The classes were smaller, only twenty people, and I could get away with being less interactive. I could take the blue book home and work by myself.”

“What about the Adderall?” I asked.

“I’d take ten milligrams first thing every morning before class. It helped me get that deep focus. But looking back, I think I just had bad study habits. Adderall helped me make up for that, but it also helped me procrastinate. If there was a test and I hadn’t studied, I’d take Adderall around the clock, all through the day and night, to cram for the exam. Then it got to where I couldn’t study without it. Then I started needing more.”

I wondered how hard it had been for him to acquire additional pills. “Was it hard to get more?”

“Not really,” he said. “I always knew when a refill was due. I’d call the psychiatrist a few days before. Not a lot of days before, just one or two, so they wouldn’t get suspicious. Actually, I’d run out like . . . ten days before, but if I called a few days before, they’d refill it right then. I also learned it was better to talk to the P.A., the physician’s assistant. They’d be more likely to refill without asking too many questions. Sometimes I’d make up excuses, like say there was a problem with the mail-order pharmacy. But most of the time I didn’t have to.”

“It sounds like the pills weren’t really helping.”

David paused. “In the end, it came down to comfort. It was easier to take a pill than feel the pain.”

In 2016, I gave a presentation on drug and alcohol problems to faculty and staff at the Stanford student mental health clinic. It had been some months since I’d been to that part of campus. I arrived early and, while I waited in the front lobby to meet my contact, my attention was drawn to a wall of brochures for the taking.

There were four brochures in all, each with some variation of the word *happiness* in the title: *The Habit of Happiness*, *Sleep Your Way to Happiness*, *Happiness Within Reach*, and *7 Days to a Happier You.* Inside each brochure were prescriptions for achieving happiness: “List 50 things that make you happy,” “Look at yourself in the mirror [and] list things you love about yourself in your journal,” and “Produce a stream of positive emotions.”

Perhaps most telling of all: “Optimize timing and variety of happiness strategies. Be intentional about when and how often. For acts of kindness: Self-experiment to determine whether performing many good deeds in one day or one act each day is most effective for you.”

These brochures illustrate how the pursuit of personal happiness has become a modern maxim, crowding out other definitions of the “good life.” Even acts of kindness toward others are framed as a strategy for personal