Psychiatry killed Tuva Andersson whose problem was anxiety

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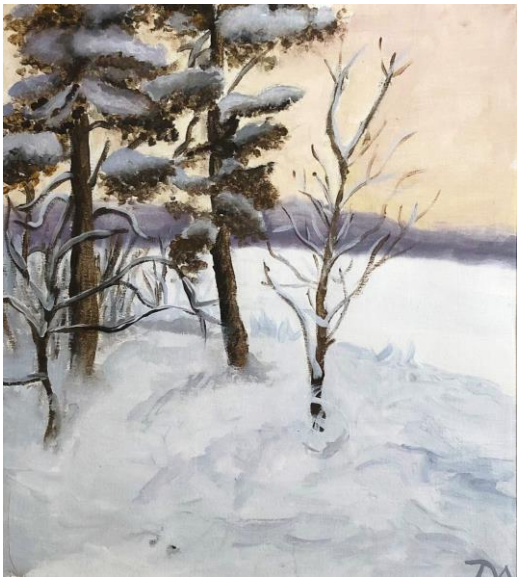
In my book, "Deadly Psychiatry and Organised Denial," I told of how psychiatric drugs kill millions of people each year. I have estimated, based on randomised trials and good comparative cohort studies and reviews of such research, that psychiatric drugs are the third leading cause of death, after heart disease and cancer. This might be an exaggeration but there is no doubt that psychiatric drugs have killed millions. Further, some of these drugs, e.g. neuroleptics and depression drugs, do not even have clinically relevant effects according to the psychiatrists' own research.

Electroshocks also kill, with a death rate of about one per 1000. And psychiatrists kill patients indirectly by taking away their hope, which drives some patients into suicide. Psychiatric institutions provide an environment that predisposes strongly to suicide. As I have explained elsewhere:

A Danish register study found that admission to a psychiatric ward increased the suicide risk 44 times, and, surprisingly, the potential biases in the study were conservative, i.e. favoured the null hypothesis of there being no relationship. An accompanying editorial noted that there is little doubt that suicide is related to both stigma and trauma, and that it is entirely plausible that the stigma and trauma inherent in psychiatric treatment – particularly if involuntary – might cause suicide. The editorialists believed that a proportion of people who commit suicide during or after an admission to hospital do so because of conditions inherent in the hospitalisation.

The gruesome story of Tuva Andersson


Tuva Andersson


Painting by Tuva Andersson

Tuva Andersson was 37 years old when she committed suicide in 2019 in her apartment where she lived alone in Sweden. Her mother, Karin Hjelm, wanted me to tell her story hoping it might prevent other tragic and unnecessary deaths. Karin gave me access to Tuva's medical records and other documentation based on which I wrote a 60-page report I shall summarise here.

Tuva was an artistic person who played music and painted. Such people are often sensitive, and Tuva had some social difficulties and suffered from anxiety.

Tuva's problems should have been handled by psychosocial interventions. Instead, she was snowed under with a dangerous cocktail of psychiatric polypharmacy, and she was stigmatised by a variety of fluffy, ever changing, and unspecific diagnoses.

At a psychiatric department where she was an in-patient, Tuva was accused by a member of staff to have set newspapers on fire and to have tried to escape. Karin disputes it was Tuva who started the fire, and Tuva also denied it. The evidence for this appears to have been very scant or non-existing, but what was written in her medical records was believed even though it contrasts importantly with information in the police report. Tuva was never convicted by the police but was condemned by the department's chief psychiatrist, Daniela Schmitt. Karin has required the police to investigate this.

Tuva was briefly jailed and was then transferred to a department of forensic psychiatry, which increased her suicide risk markedly. The transferral was based on testimony from Schmitt who exaggerated the facts to ensure Tuva got incarcerated and became treated with a depot neuroleptic even though she was not psychotic.

Even if Tuva *had* started the fire, she should not have been treated with a depot neuroleptic or transferred to a department of forensic psychiatry. Starting a fire is an understandable reaction to inhumane conditions and a desperate call for getting help from those who refuse to listen to their patients.

Important factors that led to Tuva's death were professional incompetence, gross medical negligence, malpractice, polypharmacy with psychiatric drugs, and forced treatment with a depot neuroleptic. Tuva would likely not have died if the psychiatrists had not ignored her observations, wishes, and crucial questions.

During the last year of Tuva's life, her psychiatrists took away her hope of ever leaving psychiatry and becoming better, which is the worst thing a psychiatrist can do to a patient, as it increases the suicide risk dramatically.

During this time, Tuva was at very high risk of suicide; she had nothing to live for; and yet the psychiatrists' only concern was to continue to write prescriptions for drugs that clearly harmed her. When Tuva had difficulty concentrating and focussing or had other issues, the psychiatrists consistently ascribed this to her psychiatric "illness," not to their drugs, in contrast to some alert nurses.

Tuva so much wanted to come off her drugs but the psychiatrists ignored her. And she did not get the psychotherapy she requested repeatedly, which would likely have saved her life.

Tuva knew more about her condition than the psychiatrists did. She knew that her main problem was anxiety, which worsened in stressful situations; that everything else came from this; and that if this could be handled, she would be okay.

After I had done my assessment, I read a highly critical post-mortem complaint by chief physician Maarit Wirkkala and a highly critical post-mortem assessment by psychiatrist Albert Stephan.

Stephan concluded that there was no evidence to justify the transfer of Tuva to the forensic department; that the psychiatrists omitted to perform relevant tests and assessments (not even the psychotic traits that were described had been further assessed); that it was not clear what kind of care Tuva received; and that a person with a high suicide risk was discharged with a message that she should take care of herself.

Stephan's judgment was that the observable symptoms had not been interpreted in a way that is expected by an experienced psychiatrist and that it is likely that Tuva's death was caused by the lack of investigations and the treatment she received. I agree.

Stockholm 2012: widespread ignorance and substandard practices

Most psychiatrists knew far too little about the drugs they prescribed to Tuva. In 2012, despite the fact that there were no psychotic symptoms, Eric Olsson at Danderyd's psychiatric department started her on 5 mg olanzapine daily, which he erroneously called "a small dose."

Olsson opined Tuva was borderline psychotic but there was no evidence for this and borderline psychosis is not an approved indication for olanzapine. It was also unclear what he meant by Tuva having "neuropsychiatric issues." She lived with a boyfriend and studied mathematics at a high level at the university. She had difficulty concentrating and olanzapine makes it more difficult for people to think and concentrate.

Tuva had received zopiclone, a sedative z drug, for quite some time but even though all doctors know that benzodiazepines and z drugs must only be used short-term because of their addiction potential, Olsson continued with this drug, with no plan for tapering and stopping it.

It is also well-known that a combination of a neuroleptic and a benzodiazepine or a z drug increases mortality. The Danish National Board of Health warned against this in 2006 noting that it increases mortality by 50-65%. Olanzapine in itself, and other neuroleptics, double mortality compared with placebo.

Another psychiatrist, Andreas Irwinger, mentioned Tuva's anxiety but also strongly suspected neuropsychiatric disorder and autistic spectrum disorder. Neuropsychiatric disorder is a "blanket medical term that encompasses a broad range of medical conditions that involve both neurology and psychiatry. Common neuropsychiatric disorders include: seizures, attention deficit disorders, cognitive deficit disorders, palsies, uncontrolled anger, migraine, headaches, addictions, eating disorders, depression, anxiety."

Thus, it is a nonsense diagnosis. One cannot strongly suspect something that is so vaguely defined and encompasses so many different conditions.

It is obvious that symptoms of autism spectrum disorder could be drug harms, but very few of Tuva's many psychiatrists considered if her symptoms could be caused by the drugs, she received.

Irwinger started treatment with oxazepam. It is very bad medicine to prescribe two minor tranquillisers plus a major tranquilliser for a math student who has difficulty concentrating.

At follow-up, Tuva not only had difficulty concentrating, but also an intermittent feeling of unrest in the body. Irwinger did not consider if this could be akathisia, a horrific drug harm that increases the risk of suicide, violence and homicide.

Tuva noted that she would try to stop taking zopiclone shortly but Irwinger did not warn her about withdrawal symptoms or provided her with tapering guidance.

Tuva was seen by psychologist Karin Bergman who tested her for adult ADHD and found she very likely had this. However, the test Bergman used is an extremely poor one although it is officially recommended. When I lecture for various audiences, including doctors, psychologists, and social workers, it never fails that between one quarter and one half test positive when I ask them to try this test.

When Tuva visited Irwinger again, she mentioned she might want to try to come off olanzapine. But Irwinger wrote "we agree" (which was not the case) that it was not an appropriate time to change the dose of olanzapine because Tuva in a short while would resume her studies, which usually caused tension. This is not a legimite reason for prescribing a neuroleptic.

Tuva now received not only olanzapine and two sedatives but also escitalopram, a depression drug, and an antihistamine. This is also very bad medicine. It has never been documented that any of these classes of drugs improve functioning. In fact, they all impair functional ability.

Tuva's incompetent psychiatrists put her on a downhill course in 2012 with polypharmacy she never escaped from despite multiple tries.

Hudiksvall 2018: gross incompetence and misleading statements

I did not study what happened to Tuva between 2012 and 2018 when she was admitted to the psychiatric ward in Hudiksvall after a suicide attempt. She felt isolated and insecure when meeting other people and had been on sick leave for two years. She had prepared a noose but was too scared to commit suicide and told her mother about her suicide plan.

Tuva had herself withdrawn from both clonazepam and diazepam, but was still in treatment with two other sedatives, oxazepam and zopiclone, and now she also received amitriptyline, a tricyclic depression drug. Tricyclics are very dangerous in overdoses and Tuva ultimately killed herself with this drug.

According to her medical records, Tuva made a fire in a room, which she should have admitted to the police while a nurse was present who saw her attempt to escape from the department and hindered it. Karin disputes this, which also contrasts with the police report. The hospital records might be misleading and self serving in order to defend the department's decision to send Tuva to a department of forensic medicine in Säter.

It has been documented many times that medical records at psychiatric hospitals can be seriously misleading and psychiatrists might lie routinely in court to get their will, too.

Tuva was taken by the police that reported she had refused to take her drugs at the police station and had become agitated. This was likely a withdrawal symptom, and Tuva calmed down when she resumed her drugs. It might have been akathisia, which psychiatrists often describe euphemistically with the term agitation.

At the police station, psychiatrist Grósz Pál Sándor stated that Tuva had been tapered off the sedatives. This was misleading, as it means someone else did it, but it was Tuva herself who stopped

taking the drugs. She was *not* helped by her psychiatrists who renewed her prescriptions year after year, which is serious malpractice.

Sándor mentioned dissociative tendencies and a borderline psychosis. I did not find any evidence that could justify a psychosis diagnosis.

Chief psychiatrist Daniela Schmitt described Tuva as a very seriously ill person, a rather hopeless case with serious psychiatric derangement, chronic and serious depression with psychotic symptoms, some affective issues, anxiety, being unreliable and ambivalent, having lack of impulse control, and having "neuropsychiatric issues" needing around the clock psychiatric care.

I do not agree at all with this damning judgment, and Schmitt did not even know Tuva who was admitted the same day. But it was Schmitt who decided that Tuva must be transferred to the forensic psychiatric unit in Säter. This is a place where deeply psychopathic killers and dangerous patients with schizophrenia are kept, sometimes for life. This was also where any hope of a better future, outside psychiatry, was taken away from Tuva.

Tuva wanted to stop with amitriptyline, which had not helped her and had given her a dry mouth, but yet again, she got no help, even though chief psychiatrist Simona Neverauskiene noted that her suicide risk was high and even though every psychiatrist knows that amitriptyline is an effective suicidal agent. Tuva told her psychiatrist that the reason why she suffered from pronounced anxiety and stress hypersensitivity could be that she had tapered off the sedatives. What she described are well-known withdrawal symptoms of benzodiazepines but her psychiatrists suffered from collective denial that the drugs could be her problem.

Neverauskiene claimed that Tuva could not judge her need of treatment, but this was exactly what she could, and she was correct in her judgment, in contrast to her psychiatrists. Neverauskiene described in detail that Tuva was highly restless, which should have raised a suspicion of drug induced akathisia, but nowhere in the files did I see any doctor suspect akathisia.

In the final notes, before Tuva was transferred to Säter, Dr Victoria Skoglund wrote that the psychiatric drugs that had been tried, including amitriptyline, had not had any effect.

It is malpractice to require that Tuva must continue taking all these psychiatric drugs when the psychiatrists admitted that they didn't work. It has been said that the definition of insanity is doing the same thing over and over and expecting a different result.

By this definition, Tuva's psychiatrists were insane and they were also disrespectful. They deliberately ignored the scientific evidence, their clinical experience with Tuva, and Tuva's own experiences and repeated wishes.

Säter 2018: incarceration and abuse at a forensic psychiatric department

When Tuva arrived in Säter, she was not in treatment with olanzapine or any other neuroleptics. But she was immediately started on paliperidone even though there was absolutely nothing in the medical records that justified treatment with a neuroleptic. Tuva was not psychotic and did not have psychotic symptoms on admission but the diagnosis was nonetheless intermittent depression with psychotic symptoms.

According to chief psychiatrist Vladislav Rushkin there had only been suspicions of low-grade psychotic symptoms in Tuva's past, but he nevertheless approved treatment with paliperidone.

Rushkin aggravated Tuva's situation substantially. He mentioned histrionic traits in her personality, i.e. being excessively theatrical or dramatic in character or style, and also possible antisocial traits, with difficult-to-explain deviant behaviour including arson. Rushkin noted that because of Tuva's non-compliance with the prescribed drugs, she must be treated with depot paliperidone.

Tuva was now doomed. She could not escape from the depot injections like patients often escape tablets by spitting them out when nobody is watching.

Tuva's behaviour was not difficult to explain at all. She tried to escape from the psychiatric drugs that did not work and harmed her. This, Rushkin arrogantly called non-compliance.

Rushkin wrote that Tuva had unspecified acute psychosis, which was not correct, and that she had an unspecified dissociative disorder and an unspecified personality disorder. The fact is that Tuva's appearance on admission was pretty normal.

Rushkin's utterings and actions provide a horrific example of punishing the patient instead of trying to understand her, and they made Tuva's situation much, much worse. On top of this, the very next day, a third doctor described Tuva as normal. She looked for something meaningful to do while at the department and mentioned that the depot injection led to muscular tensions and anxiety. She was sad, but Rushkin continued with the neuroleptic, which is not indicated for sadness.

Tuva said it was difficult to gather what was expected of her when asked questions. This is a well-known phenomenon. Patients in closed wards often try to figure out what the "right answers" should be in order for them to be released, and many patients therefore say the neuroleptic has helped them even when it has harmed them. If they say otherwise, it will usually lead to an increase in dose or additional drugs and postpone their release from the department.

Nurse Linda Norgren noted that on the day before the next depot injection, Tuva exposed clear signs of unrest/stress/anxiety. It is typical that some of the most important information about the patients in psychiatric departments comes from nurses and other ward personnel, not from the psychiatrists who are obsessed with making diagnoses and prescribing drugs. Tuva was clearly afraid of the neuroleptic, but Rushkin didn't care and didn't care either that she was not psychotic or that the extensive polypharmacy was dangerous.

Rushkin noted that Tuva didn't want to remain at the clinic, which she perceived as a game, and that she refused to reply to additional questions. He opined that Tuva had a slightly aberrant behaviour; that he continued to suspect "psychotic symptoms;" and that she would therefore need to stay at the ward the coming weeks and would continue getting injections. She reacted strongly to this and slammed the door.

Rushkin wrote that Tuva some days ago had said she would like to stay at the department, and he interpreted this as a clear sign of continuing instability, which meant she still needed to be incarcerated and subjected to forced injections if she did not accept them voluntarily. This is deeply ironic. Psychiatrists change their opinions all the time but they do not receive forced injections.

It is heart-breaking that everything Tuva said or did was used against her in a way that aggravated her situation. Considering what Rushkin did to her, it was a mild reaction to get angry and slam the door. Others might have slapped him in the face.

The nurses noted that Tuva experienced the interactions as a theatre and that she wanted to know why she was treated as she was.

It seems to me that internationally agreed guidelines about the duty to inform the patient before an injection with a neuroleptic under the threat of force if she does not comply had not been adhered to. Nowhere in the records did I find any note that Tuva had been properly informed about the effects and harms of the neuroleptic, or that she had been motivated to accept the injections, which is required by law in Denmark. This looked like serious malpractice.

Tuva reacted strongly also ahead of the next injection, and she protested by stopping taking one or more of her drugs, which might have caused a withdrawal reaction. The psychiatrists did nothing but continued on the dangerous path they had laid out for her. It is no wonder that psychiatric patients often perceive a close ward as worse than a prison.

Then, a rare type of psychiatrist, Knut Sturidsson, stepped into the scene. He understood much more than his colleagues. He understood that Tuva's fundamental problem was anxiety, which could develop into panic, and he wrote it could be treated with psychotherapy, which was also what Tuva wanted. He observed that Tuva suffered from paranoia, e.g. thought that ads on TV were directed against her or that telephone calls were monitored. Tuva had thoughts about suicide and about hopelessness and being worthless, which were likely aggravated by her stay at the closed ward. Indeed.

Anxiety is a key symptom in psychiatry, and it is well known that extreme anxiety can lead to psychotic symptoms in the form of paranoia. But neuroleptics do not have any specific effect on paranoia or psychosis, they are merely major tranquillisers, which was their original name. Depression if often a secondary effect of anxiety, and other issues are also related to anxiety. This has been described by psychiatrist Niall McLaren in an excellent book.

A nurse noted that Tuva developed strong anxiety after having dropped her sleeping pills for a few days, and Tuva repeated she wanted to have her drugs tapered off. But yet again, the psychiatrists ignored her wishes totally and did not even warn her about withdrawal symptoms. During a whole month, Tuva had planned to self-harm in order to die, but her risk of suicide was nonetheless called difficult to assess.

Nurse Carolina Silfver described serious harms of paliperidone that made it impossible for Tuva to do what she liked, e.g. move around and play piano, and her cognitive abilities were much reduced, but Rushkin didn't care. Ten days later he even opined that the neuroleptic had helped Tuva. This is close to being delusional. As expected, randomised trials have shown that neuroleptics worsen cognitive functions.

Rushkin suspected Tuva would stop with her medication when she was no longer controlled by him and his colleagues, but instead of designing a plan for drug withdrawal, he did the opposite, arguing that it would lead to a serious deterioration of her condition if she stopped with the drugs. This was also totally wrong. Sedatives stop working pretty quickly and the randomised trials have shown that depression drugs and neuroleptics don't have clinically relevant effects (see Critical Psychiatry Textbook, which is freely available).

If tapering had been started, with one drug tapered at a time, in a hyperbolic fashion where the dose reductions become smaller and smaller to minimise withdrawal effects, Tuva would have obtained what she wanted and her condition would have been much better.

Nurse Linda Norgren noted that Tuva received trihexyphenidyl, an anticholinergic drug used against dystonia, which is typically seen in Parkinson's disease but can also be a harm caused by neuroleptics. I have not seen any deliberations in Tuva's medical records in relation to this drug.

Rushkin wanted to continue with paliperidone injections every month also after Tuva had left the department. He ascribed all improvements to himself and the neuroleptic he forced Tuva to accept.

However, at a follow-up, nurse Pia Hildingsson noted that Tuva still suffered from muscle stiffness. This could very well be a harm of the drugs Tuva received and has been described both for amitriptyline and paliperidone. Yet again, in this tragic story we get the most important information from the nurses, and the psychiatrists did not react to the harms they caused but instituted yet another drug, used for Parkinsonism.

Chief psychiatrist Mehmet Hasanogullari mentioned muscle stiffness and pain on movement and considered the dose of paliperidone too high. He recommended lowering of the dose and a change of drug to aripiprazole depot if the harms continued.

When Rushkin transferred Tuva back to Hudiksvall, his letter to the prosecution demonstrated his incompetence. He mentioned aberrant behaviour; replies with a long latency; lack of response; that Tuva saw everything around her as a game; that she had psychotic symptoms; that she was against getting a depot neuroleptic (which was therefore in reality forced treatment); that she still needed to be at a closed ward because of a serious psychiatric disorder in the form of a psychosis; that she needed around the clock psychiatric care; had suicidal thoughts; lacked insight into her disease; and could not provide informed consent to what was offered to her. The one who lacked insight into Tuva's disease was not her, but Rushkin.

Rushkin destroyed Tuva and took away all her hope. It must have been a huge trauma for her to be at his department.

Hudiksvall's psychiatric department 2018-2019

After three months at the forensic psychiatric department in Säter, Tuva came back to Hudiksvall. She suffered a lot from anxiety, which got worse after the injection. Her periods disappeared and she developed milky nipple discharge. She was therefore switched to aripiprazole depot injections. In contrast to the opinion of Rushkin, psychiatrist Mehmet Hasanogullari noted that Tuva had insight into her disease.

Tuva was now an outpatient. Psychiatrist Melinda Miklos mentioned that almost all of Tuva's previous drugs had caused terrible side effects. These drugs included at least four different depression drugs, three different neuroleptics and an anti-epileptic even though the package inserts warn that anti-epileptics double the risk of suicide.

When Tuva asked which diagnoses she had, Miklos told her she had no established diagnoses, only unspecified ones. However, when Tuva asked for psychotherapy, as she was traumatised, Miklos

replied that it should first be established which diagnoses she had. This was absurd, also because effective psychotherapy can be provided without having any specific diagnoses.

Clearly, the psychiatrists, even the best ones, were trapped by their false belief system within the boundaries of biological psychiatry and their unscientific diagnoses.

In February 2019, Tuva was seen acutely because of suicide plans and preparations for hanging. She had no social contacts apart from her parents who had their own problems and she saw no way out other than suicide.

Tuva still complained of muscle pain, viewed her drugs as a major problem, and wanted to consult a psychologist, but she was yet again ignored.

At a follow-up visit, Tuva asked again for a psychologist. She had dark thoughts about everything and no hope that it would change. The chief psychiatrist Daniela Schmitt was present at the meeting but ignored yet again Tuva's deepfelt wish to get into contact with a psychologist. Tuva never got the psychotherapy that might have saved her life.

The psychiatrists should have known better. A 2017 meta-analysis of the randomised trials showed that cognitive behavioural therapy halves the risk of a new suicide attempt in patients admitted acutely after a suicide attempt, just like Tuva was. A year earlier, a more broad review, which included studies of self-harm, arrived at similar results. There was therefore no excuse for the psychiatrists not to have known about these important results in 2019.

Tuva was seen by a psychologist, Marcela Golap, which was very revealing. Tuva wanted to know what was behind the diagnoses of psychosis, dissociative syndrome and recurrent depression, and why the diagnoses changed every time she saw a new psychiatrist. She continued to perceive her problems as secondary to anxiety and stress.

Tuva did not understand why she was now in such poor condition, but Golap understood her and would try to arrange psychotherapy. Seven years earlier, another psychologist saw the need for further evaluation but nothing was done for Tuva in all these years that could have helped her.

Tuva wondered if stopping a benzodiazepine can cause psychosis, which it surely can, and this has been known for decades. Again, Tuva demonstrated better knowledge of the effects of psychiatric drugs than her psychiatrists did.

Unfortunately, Golap's good intentions came to nothing, as she stopped working at the ward. Tuva continued to ask for access to a psychologist but was overheard.

At a visit in April 2019, Miklos told Tuva that oxazepam is a relative contraindication for psychotherapy, but Tuva could very well have benefited from psychotherapy while on oxazepam and she took it very rarely. Miklos noted something about tapering off amitriptyline but there was nothing in Tuva's files about this, which must be done according to a plan and under careful supervision. She mentioned that Tuva had consulted a psychologist about 10 times when she lived in Stockholm to learn how to handle anxiety and stres when she tapered off benzodiazepines.

Tuva said she would commit suicide if she did not feel her situation improved and promised to contact psychiatry if she started making plans for suicide. Miklos was aware of the very strong warning signals about suicide, which can occur at any time, and she also realised that psychological treatment

was essential. This is the first time I saw any psychiatrist say this and Miklos referred Tuva to psychotherapy. Two weeks later, this treatment was prioritised but there was a waiting list.

Tuva received zopiclone, oxazepam, amitriptyline, aripiprazole depot injections, promethazine and propranolol, which harmed her considerably. She had reduced cognitive functions, memory problems, concentration difficulties, monotonous speech, difficulty keeping focus and planning, starting and finishing tasks, and she was very isolated.

In May 2019, Miklos repeated at a treatment conference that psychotherapy was highly relevant because the drugs had not had "enough" effect. It is the other way around: Drug treatment had made Tuva's situation much worse and had set her on a suicide course. The situation was critical for Tuva, but the department decided that she would be summoned for psychotherapy within a couple of months. This was serious malpractice. Tuva was in acute need of psychotherapy.

Tuva was very consistent about her suicide plans and the psychiatrists must have known that this would likely end in disaster. Yet, they did nothing to taper off her drugs, in particular the neuroleptic, which was given as a forced depot injection so that Tuva could not escape it.

This serious violation of human rights has been criticised by Dainius Pūras, former Special Rapporteur at the United Nations (2014-2020) and current Professor and Head of the Centre for Child Psychiatry Social Paediatrics at Vilnius University. The United Nations Convention on the Rights of Persons with Disabilities specified in 2014 that at all times, the individual autonomy and capacity of persons with disabilities to make decisions must be respected, which means that "mental health laws that permit forced treatment must be abolished."

During this period, Tuva was seen weekly at the hospital. She had suicidal thoughts all the time. The questionable psychosis diagnosis had been withdrawn but the depot injections with aripiprazole continued and other drugs were also continued.

The medical records were highly misleading. Something was called psychotherapy, but nothing was written at the first visit about concrete psychotherapy or which form of therapy it was, indeed, if any psychotherapy was offered at all. It was also unclear if Peter Hedman, the person Tuva visited, was a psychiatrist or a psychologist. I was taken by surprise when I asked Tuva's mother Karin and she told me that he was neither of these. He was a curator, a social worker, which she documented.

Hedman wrote his notes under the heading "Psychotherapy." At the first visit, he started out with an assessment of therapy. It is not the task for a social worker to assess the treatment a psychiatric patient receives.

After Tuva's suicide, Karin complained about malpractice. An official body, "Inspektionen för vård och omsorg" (Inspection of Care), criticised the department for letting a curator take care of Tuva in the last three months of her life when a change in drug treatment occurred and also considering the suicide risk.

The curator was totally incompetent. On 11 June, he opined that Tuva's suicide risk was low, but later the same day she was admitted acutely to the department to prevent suicide. Tuva had taken an overdose of zopiclone to help her dare commit suicide and she had put a chair under a noose, but did not remember any of this. She woke up when the ambulance arrived. There was nothing in her records about how she was found but when the hospital discharged her one and a half months later, they noted that she had sent a text message to SOS that she was about to kill herself. In addition to her usual

drugs, she was now on the anti-Parkinson drug again, and she still received aripiprazole tablets, in addition to the depot injections.

Her medical records on admission said: “Risk factors for suicide: Long-term psychosis disease.” This was plain wrong and this diagnosis had even been withdrawn.

Tuva told a nurse that she was disappointed that her suicide attempt failed. Even though Tuva’s suicide risk was very high, the department did not institute constant surveillance of her, so she could easily have killed herself during the night. This is extremely serious malpractice and it continued. Three days after admission, the department, including chief psychiatrist Simona Neverauskiene, decided to stop amitriptyline cold turkey over the weekend.

Stopping a depression drug abruptly increases the risk of suicide markedly, which every psychiatrist knows. According to the European Medicines Agency and the package insert, amitriptyline “should be gradually withdrawn over several weeks.”

The package insert also documents that many of Tuva’s problems could be harms of amitriptyline. Very common harms include aggression, somnolence and speech disorder, and common harms include confusional state, agitation, and disturbance in attention.

The department decided to treat Tuva with vortioxetine, which is far more expensive than off-patent depression drugs, and not better than those, but actually worse, which yet again illustrates that the psychiatrists were very far from being evidence-based.

The medical records were contradictory. At first, amitriptyline would be stopped cold turkey on a Friday, but a tapering over 6 days was also described, with no details. At any rate, stopping the drug so quickly went against official guidelines and gave a high risk of dangerous withdrawal symptoms, which could be lethal.

The farcical meetings with curator Hedman continued. He did not in any way deal with Tuva’s issues even though they were so well described by psychologist Marcela Golap two months earlier. Tuva’s suicide risk was very high but he considered it difficult to judge.

Tuva so much wanted to see a psychologist but what she got was a social worker who was unable to help her. This must have pushed her further downhill towards suicide.

On 20 June, chief psychiatrist Simona Neverauskiene wrote in the files that Tuva had met with “her psychologist Peter.” She did not even know that Heman was not a psychologist. Tuva said she benefited from meeting Heman, but this could be a strategy to reduce the risk that the planned psychotherapy would be cancelled. After a long “career” in psychiatric institutions, Tuva knew what to say and what not to say.

Tuva’s last two months

Unsurprisingly, Tuva developed abstinence symptoms after the abrupt reduction of the amitriptyline dose. And when she started on vortioxetine, she got side effects including nausea and the dose was lowered. At a visit on 25 June, Tuva promised not to commit suicide during her stay at home over the weekend, but such a promise from a person with a very high suicide risk is worthless.

A week later, at a meeting where chief psychiatrist Daniela Schmitt was present, the psychiatrists acknowledged again the high suicide risk but did not act accordingly, and Tuva continued with her meaningless meetings with Hedman. He repeated what he had already written and what the psychiatrists had written again and again in Tuva's medical records. There was absolutely nothing in Hedman's notes about how he would attempt to prevent suicide.

At a visit on 18 July, where chief psychiatrist Simona Neverauskiene was present, Tuva said she did not have suicide plans at present but that they came and went. She suffered from hopelessness and lack of meaning, had insight into her "disease" and behaved in a "help seeking way." Yet, no one provided the help she needed.

On 22 July, Tuva saw Hedman again. He now considered her suicide risk low! This was catastrophic. The psychiatrists should immediately have stopped these meetings and should have arranged for Tuva to be seen by a psychologist as an emergency.

Hedman continued to write in Tuva's records what was already known and supplemented this with trivial issues about what happened when she went to school twenty years earlier. I have never seen anything so horrible in my whole life in terms of the lack of professionalism in treating a person at high risk of suicide who has lost all hope and meaning with life.

Two days later, Neverauskiene met with Tuva. She was still at high risk of suicide, she had nothing to live for, and yet the only concern the staff had, including Neverauskiene, was to continue to write prescriptions for Tuva for drugs that harmed her even though the whole idea with admitting her to the department was to prevent suicide.

The same day, Tuva was discharged from the hospital. In consultation with chief psychiatrist Daniela Schmitt, Tuva was "encouraged to take the initiative herself and the responsibility for follow-up."

The psychiatrists told Tuva to fend for herself and take responsibility after they had themselves not done that. This was utterly irresponsible, particularly considering the massive harms they had inflicted on her, including taking away any hope. They wrote in the final notes that she had reduced capacity to look after herself. That's no wonder considering the drug cocktail she was on. But how could they then, at the same time, assign this responsibility to her? It looks like collective cognitive dissonance.

On this day, the department, including Schmitt, acknowledged that sedatives are habit forming, but they continued to prescribe zopiclone and oxazepam for Tuva instead of instituting a plan for tapering off these drugs. This was also serious malpractice.

Two days after discharge, Hedman had telephone contact with Tuva and wrote: "The patient will continue having contact with the undersigned for psychotherapy once a week." I seriously doubt that what he provided for her deserved this name. What were his qualifications to practice psychotherapy, which involves a pretty long education? How is it possible to perform therapy and then write absolutely nothing about what type it is, what it involves, how Tuva reacts, and what the outcome is?

On 6 August, Tuva met with Hedman again. His notes were once again pretty meaningless and did not suggest any kind of psychotherapy had been carried out. Worst of all, Hedman again considered Tuva's suicide risk low. They also met on 12 and 19 August and on both occasions Hedman considered Tuva's suicide risk low. Six days later, Tuva killed herself.

Tuva's problem was anxiety. But the diagnoses I found in her medical records were all over the place. They included borderline psychosis, neuropsychiatric issues, neuropsychiatric disorder, chronic depression, autistic spectrum disorder, mixed anxiety and depressive state, unspecified depressive episode, dissociative tendencies, serious psychiatric derangement, and serious chronic depression with psychotic symptoms.

Post-mortem complaint by chief physician Maarit Wirkkala

In February 2020, Region Gävleborg received a complaint from chief physician Maarit Wirkkala. I had not seen this before I had written a full report about Tuva's medical records and had made my own judgment.

I agree entirely with Wirkkala. Tuva was discharged to the police after the fire without an assessment by a doctor of the need for care, and she was denied medical examination in the prison even though the police said this was needed.

The diagnostic examinations that were requested in the transferral to Säter were not carried out. When discharged to her home, Tuva's relatives were not informed about a recent suicide attempt or the increased suicide risk. No assessment of whether Tuva could care for herself, i.e. could handle the drugs herself, was carried out. No review of which drugs she had access to from previous prescriptions was carried out (she suicided by a drug overdose).

"As shown by the attached event analysis and Internet investigation … several deficiencies have been identified." These included lack of knowledge about the law for compulsory psychiatric care, which, together with the deficiences related to assessment of self care and the handling of drugs, had the direct consequence that Tuva's mental health was worsened with subsequent suicide.

The time Tuva spent in jail and during forensic care had devastating consequences with respect to quality of life and recent trauma, which she never recovered from. A careful diagnostic assessment, good care and adequate treatment when Tuva first arrived in September 2018 would likely have avoided the subsequent course with a crime, arrest and forensic psychiatry.

During the initial care, copies of medical records were ordered from Stockholm but only those from Mörby arrived and with too little documentation. If information from relatives, the patient and earlier care staff had been thoroughly mapped, the ensuing diagnostics and treatment would likely have been more adequate and effective.

During care, conflicts between staff and relatives occurred, which did not benefit Tuva's treatment or well-being. During 2019, Tuva was considered to have chronically increased risk of suicide, but she was not assessed according to criteria for self-care, i.e. if she could handle her drugs herself. If a mapping had been carried out about access to prescriptions and drugs, and if drug treatment had been handled by the psychiatric out-patient clinic, Tuva's access to suicidal drugs had been reduced and the suicide could possibly have been avoided.

Post-mortem assessment by psychiatrist Albert Stephan

I did not read this either before I had made my own judgment. I agree entirely with the psychiatrist, Albert Stephan, whose evalutation is from January 2021. According to Tuva's mother, this evaluation was done on behalf of the county council's insurance company.

Stephan wrote that the care and treatment of Tuva had been deficient. Despite the increasing suicide risk, corresponding interventions were not introduced. There was no evidence justifying the transfer of Tuva to the forensic department and no close coordination occurred.

The diagnostic issues were not followed up upon and no psychological tests were carried out. Not even the psychotic symptoms were further assessed. Stephan wrote that observable symptoms were not interpreted in a way that is expected by an experienced psychiatrist.

In addition, it was difficult to know which kind of care Tuva received, i.e. if it was according to the common law for all patients or if it was according to the law for compulsory psychiatric care.

Despite insufficient knowledge about what the most recent drug changes had led to and signs of mental instability with chronically increased suicide risk, Tuva was discharged from the department with an encouragement to take the initiative and responsibility for follow-up herself.

Stephan believed that the suicide risk could have been "considerably mimimised" by better coordination between the involved institutions, assessement of the suitability of giving Tuva responsibility of handling her drugs and by more intensive investigations.

Stephan concluded that it likely that Tuva's death was caused by the lack of investigations, treatments and other such interventions.

I agree with this conclusion. The psychiatrists are responsible for Tuva's death.

Autopsy report

The forensic autopsy showed that the cause of death was intoxication with amitriptyline and zopiclone.

This is significant. Tricyclic antidepressants are rarely used today because they are dangerous in overdoses and have caused many suicides. There was no good reason to prescribe amitriptyline to Tuva and no one ensured she didn't have too many of these pills at home.

Conclusions

Tuva's fate is not unique or rare. In Denmark, a patient with a similarly tragic story as Tuva's, Luise Christensen, fell asleep in her bed while smoking a cigarette after an extraordinarily large dose of a neuroleptic, probably as a result of a medical error. The bed caught fire but a member of staff quickly extinguished it. In court, Luise got a forced treatment order which, in principle, could be for life. No one asked the staff who knew her but a chief physician who didn't know her gave testimony, which sentenced her, very much like what happened to Tuva.

Luise's sentence was used by the psychiatrists even many years later to overmedicate her, arguing how dangerous she was, and a deeply incompetent and arrogant psychiatrist refused to listen to Luise and her mother. Two years before she died, Luise said to her mother: "You can write on my tombstone that it was the medication that killed me."

Like in Tuva's story, the medical records were seriously misleading – even to the point of being fraudulent. Almost without exception, whenever Luise or her mother complained about drug side effects, the dosage of the suspect drug was increased, and in several instances, what was written in the

patient's chart was plain wrong but made the staff's actions look better. On several occasions, inconvenient correspondence with the authorities simply "disappeared."

There was only one good psychiatrist who listened to Luise and understood her, and because of him, it had been decided at a discharge conference that Luise should take as little neuroleptic medication as possible. However, the arrogant psychiatrist was present at the conference and he did the exact opposite. Luise lost all hope and asked her mother: "Mom, do you think it's better in Heaven?"

Six months before she died at age 32, Luise's best friend, who was admitted to the same hospital and stayed in the room next to her, suddenly collapsed at the floor and died within a few minutes. Luise was completely shattered and all she said to her mother was: "I'll be next."

An overdose of a depot neuroleptic ultimately killed Luise. This was called a "natural death" and Luise's death certificate said, "death from unknown causes." When Luise's mother complained, she was told that Luise had received "the highest standard of specialist treatment."

The "licence to kill" in James Bond movies has a perverse meaning in psychiatry. It is considered the highest standard of specialist treatment to kill people after having tortured them for many years with the drugs that ultimately killed them, and which they begged their torturers not to use.

Luise's mother wrote a heart-breaking book about this and founded the organisation "Death in Psychiatry" whose members have all experienced loves ones being killed by psychiatry. They demonstrate every year outside the hospital on Luise's death day.

Tuva's and Luise's stories are emblematic. They illustrate why so-called biological psychiatry with its obsession with drug treatment is so harmful that it should be stopped immediately and be replaced by a new mental health care that does not focus on neurotransmitters and unscientific diagnoses, which automatically lead to treatment with an array of harmful drugs, but on psychotherapy, other psychosocial interventions, empathy, understanding, respect, lack of force, and fully informed consent in all situations.

Many patients are killed every single day with psychiatric drugs that don't work for them. This madness must stop. "Mom, won't you tell the world how we're treated?" This was Luise's last request to her mother. I have now told the world how Tuva was treated.

A local newspaper, Hudiksvall Tidning, wrote about this in an editorial on 5 February 2020: "The personal disaster that befell this family involves so many mistakes in the chain of care that it is almost mind boggling. How is that even possible, one thinks when reading the story of Tuva. Everyone can make the wrong decision at some point. But not all the time."