# [Psychiatry killed Tuva Andersson, whose problem was anxiety](https://www.madinamerica.com/2023/07/tuva-andersson/)

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Mad in America

Tuva Andersson was 37 years old when she committed suicide in 2019 in her apartment where she lived alone in Sweden. Her mother, Karina Hjelm, wanted me to tell her story hoping it might prevent other tragic and unnecessary deaths. She also needed an expert report to be used for her complaint to the prosecutor about serious medical malpractice. This summary is based on my 60-page report.



Tuva Andersson

Tuva suffered from anxiety. This should have been handled by psychosocial interventions. Instead, she was exposed to professional incompetence, gross medical negligence, malpractice, stigmatisation by a variety of fluffy, ever changing, and unspecific diagnoses, and polypharmacy which included forced treatment with a depot neuroleptic that made it impossible for her to withdraw from it.

During the last year of Tuva’s life, her psychiatrists took away her hope of ever leaving psychiatry and becoming better. This is the worst thing a psychiatrist can do to a patient, as it increases the suicide risk [dramatically](https://pubmed.ncbi.nlm.nih.gov/24647741/).

Tuva ended up being 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 harmed her. When she 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 would likely not have died if the psychiatrists had not ignored her observations, wishes, and crucial questions. She so much wanted to come off her drugs, and she did not get the psychotherapy she requested repeatedly, which would likely have saved her life.

##### ****The gruesome story of Tuva Andersson****

Tuva was artistic and played music and painted. Such people are often sensitive, and Tuva had some social difficulties.



A painting by Tuva Andersson

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

Most psychiatrists she encountered knew far too little about the drugs they prescribed. In 2012, Eric Olsson at Danderyd’s psychiatric department started her on 5 mg olanzapine daily, which he erroneously called “a small dose.” Tuva had no psychotic symptoms, but Olsson opined she was borderline psychotic and had “neuropsychiatric issues.”

Another psychiatrist, Andreas Irwinger, strongly suspected neuropsychiatric disorder and autistic spectrum disorder. [Neuropsychiatric disorder](https://www.nicklauschildrens.org/conditions/neuropsychiatric-disorders) 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.”

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

It is also obvious that symptoms of autism spectrum disorder can be drug harms, but very few of Tuva’s many psychiatrists considered if her symptoms could be caused by the drugs she received. Despite the heavy drugging, which included a neuroleptic, a depression drug and two sedatives, Tuva managed to study mathematics at a high level at the university.

On several occasions, Tuva tapered off some of her drugs, e.g. benzodiazepines, but none of her psychiatrists warned her about withdrawal symptoms or provided her with tapering guidance. They continued prescribing benzos for many years on end, and whenever Tuva developed symptoms compatible with akathisia, a horrific drug harm that [increases the risk](https://www.amazon.com/Deadly-Psychiatry-Organised-Denial-Gotzsche-ebook/dp/B014SO7GHS) of suicide, violence and homicide, this was consistently ignored. Her psychiatrists also ignored her when she said that some of her symptoms could be drug withdrawal symptoms.

In 2018, Tuva 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 scared and told her mother about her suicide plan. One of the drugs she was on was amitriptyline, a tricyclic depression drug. Tricyclics are very dangerous in overdoses and Tuva ultimately killed herself with this drug. The forensic autopsy showed that the cause of death was intoxication with amitriptyline and zopiclone.

According to her medical records, Tuva made a fire using newspapers in order to escape from the department, but Karin disputes it was Tuva who started the fire and Tuva denied it. The medical records contrasted with the police report, and Tuva was never convicted by the police. It has been documented [many times](https://pubmed.ncbi.nlm.nih.gov/34018956/) that medical records at psychiatric hospitals can be seriously [misleading](https://www.amazon.com/Dear-Luise-powerlessness-Denmarks-psychiatric/dp/0988412209) and that psychiatrists [lie routinely](https://www.amazon.com/Deadly-Psychiatry-Organised-Denial-Gotzsche-ebook/dp/B014SO7GHS) in court.

Tuva was briefly jailed 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.

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

Schmitt described Tuva as a very seriously ill person, a 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.

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 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 she got no help, even though chief psychiatrist Simona Neverauskiene noted that her suicide risk was high and every psychiatrist knows that amitriptyline is an effective suicidal agent.

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.

##### ****The forensic psychiatric department in Säter****

The diagnostic examinations that were requested in the transferral to Säter were not carried out.

When Tuva arrived, she was not in treatment with neuroleptics and she was not psychotic. But she was immediately started on paliperidone depot injections. Chief psychiatrist Vladislav Rushkin argued that she had possible antisocial traits, with difficult-to-explain deviant behaviour including arson, and that because of her 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 was clearly afraid of the neuroleptic, but Rushkin didn’t care.

He 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, which another doctor confirmed the next day.

Rushkin noted that Tuva didn’t want to remain at the clinic and argued that since she had another opinion some days ago, this was a clear sign of continuing instability, and that she would therefore be subjected to forced injections if she did not accept them voluntarily. Allow me to say that psychiatrists change their opinions all the time without receiving forced injections.

It seems that Rushkin violated the internationally agreed guidelines about the duty to inform and motivate the patient before an injection with a neuroleptic, and the lack of knowledge about the law for compulsory psychiatric care was criticised in a post-mortem report.

During a whole month, Tuva 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](https://pubmed.ncbi.nlm.nih.gov/29493377/) [trials](https://pubmed.ncbi.nlm.nih.gov/37301832/) have shown that neuroleptics worsen cognitive functions.

Rushkin ascribed all improvements to himself and the neuroleptic he forced Tuva to accept. When a nurse noted that Tuva suffered from muscle stiffness, which can be caused both by amitriptyline and [paliperidone](https://www.accessdata.fda.gov/drugsatfda_docs/label/2017/022264s023lbl.pdf), the psychiatrists did not react to the harms they had caused but instituted yet another drug, used for Parkinsonism.

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 she was offered.

The one who lacked insight into Tuva’s disease was clearly not her, but her psychiatrist.

##### ****Hudiksvall’s psychiatric department killed Tuva****

When Tuva came back to Hudiksvall, she suffered a lot from anxiety, which worsened after each injection. Her periods disappeared and she developed milky nipple discharge, and she was therefore switched to aripiprazole depot injections.

She was now an outpatient. Psychiatrist Melinda Miklos mentioned that almost all of Tuva’s previous drugs had caused terrible side effects. These drugs included an anti-epileptic even though the package inserts warn that anti-epileptics [double the risk](https://www.accessdata.fda.gov/drugsatfda_docs/label/2015/020241s045s051lbl.pdf) of suicide.

When Tuva asked which diagnoses she had, Miklos told her she had no established diagnoses, only unspecified ones. Tuva said her diagnoses changed every time she saw a new psychiatrist.

In February 2019, Tuva was seen acutely because of suicide plans and preparations for hanging, but she continued as an out-patient even though she had dark thoughts about everything and no hope that it would change. She asked many times for psychotherapy, which was denied.

This was serious malpractice. A 2017 meta-analysis of the randomised trials showed that cognitive behavioural therapy [halves the risk](https://journals.sagepub.com/doi/10.1177/0141076817731904?url_ver=Z39.88-2003&rfr_id=ori:rid:crossref.org&rfr_dat=cr_pub%20%200pubmed) of a new suicide attempt in patients admitted acutely after a suicide attempt, like Tuva was. A year earlier, a more broad review, which included studies of self-harm, arrived at [similar results](https://pubmed.ncbi.nlm.nih.gov/27168519/).

Tuva was seen by a psychologist, Marcela Golap, who understood her and tried to arrange for psychotherapy. Unfortunately, even though Tuva mentioned she had consulted a psychologist about 10 times when she lived in Stockholm to learn how to handle anxiety and stress when she tapered off benzodiazepines, Golap’s good intentions came to nothing, as she stopped working at the ward.

Tuva said she would commit suicide if she did not feel her situation improved. Finally, a psychiatrist, Melinda Miklos, realised the danger and referred Tuva to psychotherapy. But there was a waiting list.

At a treatment conference, it was agreed that psychotherapy was highly relevant because the drugs had not had “enough” effect. Well, they had made Tuva’s situation much worse and had set her on a suicide course. The situation was critical for her, but the department decided that she would be summoned for psychotherapy within a couple of months disregarding that Tuva was in acute need of psychotherapy.

Tuva’s many drugs 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.

Tuva was consistent about her suicide plans and the psychiatrists must have known that this would likely end in disaster. Yet, they did not taper off her drugs, in particular the depot neuroleptic, which she could not escape from.

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 nonetheless 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 Karin and she told me that he was neither of these. He was a curator, a social worker, which she documented.

Under the heading “Psychotherapy,” Hedman wrote his pretty meaningless notes that did not suggest Tuva got any therapy. After Tuva’s suicide, Karin complained about malpractice, and an official body 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.

Hedman was totally incompetent. There was absolutely nothing in his notes about how he would attempt to prevent suicide. On 11 June, he opined that Tuva’s suicide risk was low, but later the same day she was acutely admitted after she took an overdose of zopiclone and put a chair under a noose. She did not remember any of this. She had sent a text message to SOS that she was about to kill herself and woke up when the ambulance arrived.

Tuva told a nurse she was disappointed that her suicide attempt failed. Even though her suicide risk was very high, the department did not institute constant surveillance of her, so she could easily have killed herself during the night.

Three days later, 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](https://www.ema.europa.eu/en/documents/referral/saroten-article-30-referral-annex-iii_en.pdf) over several weeks.”

The medical records were contradictory. At first, amitriptyline would be stopped cold turkey on a Friday, but a tapering over 6 days was also noted, with no details.

On 20 June, Neverauskiene wrote that Tuva had met with “her psychologist Peter.” She did not even know that Hedman was not a psychologist.

##### ****Tuva’s last two months****

Unsurprisingly, Tuva developed abstinence symptoms after the abrupt reduction of the amitriptyline dose.

At the weekly visits, no one provided the help Tuva needed, and Hedman continued to consider 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.

Two days later, Neverauskiene met with Tuva. She was at high risk of suicide and 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 was to prevent suicide.

The same day, Tuva was discharged to her home. Tuva’s parents were not informed about the recent suicide attempt or the increased suicide risk.

Chief psychiatrist Daniela Schmitt approved the decision that 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. 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.

No assessment was carried out of whether Tuva could care for herself, i.e. could handle the drugs herself, and no review of which drugs she had access to from previous prescriptions was carried out. This was criticised in a post-mortem complaint by chief physician Maarit Wirkkala from the region. She also noted that the time Tuva spent in jail and during forensic care had devastating consequences she never recovered from; that 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; and that 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.

Schmitt acknowledged that sedatives are habit forming, but no one instituted a tapering plan.

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, 12 and 19 August, Tuva met with Hedman and he considered Tuva’s suicide risk low every time. Six days later, she killed herself.

Tuva’s problem was anxiety. But her diagnoses included borderline psychosis, neuropsychiatric issues, neuropsychiatric disorder, chronic depression, autistic spectrum disorder, ADHD, mixed anxiety and depressive state, unspecified depressive episode, dissociative tendencies, serious psychiatric derangement, and serious chronic depression with psychotic symptoms.

##### ****Post-mortem assessment by psychiatrist Albert Stephan****

Stephan’s evaluation was done on behalf of the county council’s insurance company.

His report was damning. Tuva’s care and treatment 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; observable symptoms were not interpreted in a way that is expected by an experienced psychiatrist; 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; and Tuva was discharged from the department with an encouragement to take the initiative and responsibility for follow-up herself.

Stephan concluded that it was likely that Tuva’s death was caused by the lack of investigations, treatments and other such interventions, and that her suicide risk could have been “considerably mimimised.”

##### ****Final remarks****

Tuva’s fate is not unique. In Denmark, Luise Christensen fell asleep in her bed while smoking a cigarette after an extraordinarily large dose of a neuroleptic, probably a result of a medical error. The bed caught fire which a staff member quickly extinguished. 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.

Luise’s sentence was used by the psychiatrists even many years later to [overmedicate her](https://www.amazon.com/Dear-Luise-powerlessness-Denmarks-psychiatric/dp/0988412209), 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.”

The medical records were seriously misleading—even sometimes fraudulent. Almost without exception, whenever Luise or her mother complained about drug harms, 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 “disappeared.”

There was only one good psychiatrist who listened to Luise and understood her, and it was decided at a discharge conference that she should take as little neuroleptic medication as possible. However, the arrogant psychiatrist, who was present at the conference, 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 stayed in the room next to her at the hospital, 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 [killed Luise](https://www.amazon.com/Deadly-Psychiatry-Organised-Denial-Gotzsche-ebook/dp/B014SO7GHS). 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](https://www.amazon.com/Dear-Luise-powerlessness-Denmarks-psychiatric/dp/0988412209) about this and founded the organisation “Death in Psychiatry” whose members have all experienced a family member 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 has been a disaster, and why we need a new mental health care that is not obsessed with neurotransmitters and unscientific diagnoses, which lead to treatment with harmful drugs, but focuses on psychotherapy, other psychosocial interventions, empathy, understanding, respect, lack of force, and fully informed consent in all situations.

[Thousands of patients are killed every day](https://www.amazon.com/Deadly-Psychiatry-Organised-Denial-Gotzsche-ebook/dp/B014SO7GHS) with psychiatric drugs that don’t work for them. Luise’s last request to her mother was: “Mom, won’t you tell the world how we’re treated?”

In Sweden, an editorial in a local newspaper, Hudiksvall Tidning, stated 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.”

This is what we see in psychiatry. [All the time](https://www.amazon.com/Deadly-Psychiatry-Organised-Denial-Gotzsche-ebook/dp/B014SO7GHS).