Lily Fremaux
Psychiatric Rotation
H&P 2
05/20/2026

Name: J.G.
DOB: 05/12/2002
MRN: #######
Location: NYC Health + Hospitals Metropolitan
Date of Service: 05/18/2026
Source of information: Self
Reliability: Fairly reliable
Address: Harlem, NY

HPI:
24 y/o transgender female with a PMHx of PTSD, chronic depression/anxiety, significant trauma history including multiple sexual assaults, and recent psychiatric hospitalization at Gracie Square Hospital earlier this month for possible bipolar disorder now presenting to outpatient behavioral health clinic for intake evaluation due to ongoing dissociation, insomnia, racing thoughts, and passive suicidal ideation since discharge. Patient is currently taking olanzapine 10 mg nightly and lithium 300 mg BID following hospitalization. Reports worsening insomnia, stating that she slept from approximately 5 AM to 11 AM the night prior and from 3 AM until late morning the night before that. Despite decreased sleep, patient reports feeling energetic and not fatigued. Endorses racing thoughts, increased energy, distractibility, impulsivity, and difficulty "slowing down" her thoughts.

Patient attributes recent psychiatric decompensation primarily to severe psychosocial stressors, including recent sexual assault by a coworker, rather than bipolar disorder. She reports longstanding dissociative symptoms dating back to approximately 2016–2017. Patient describes an elaborate internal framework in which different aspects of her identity are organized as parts of a symbolic "country" called Germany. She states she chose Germany not for political reasons or "Nazi stuff," but because she views it as "a country capable of great evil and great good and everything in between." Patient describes internal "meetings," a "constitution," and multiple "parts" interacting internally. She compares communication between these parts to "overlapping radio stations." Patient brought written papers and diagrams describing this internal structure. Although patient strongly identifies with this internal framework, she demonstrates awareness that it is metaphorical/symbolic in nature rather than externally real.

Per recent hospitalization documentation from May 7, 2026, patient reportedly placed a card on her desk labeled "Han, J.G., Chancellor and Commander in Chief," accompanied by drawings of countries. Denies alcohol, tobacco, nicotine, or recreational substance use.

Patient additionally endorses significant memory impairment and dissociation, including large gaps in autobiographical memory and difficulty recalling much of her childhood. Reports chronic

depression, anxiety, emotional detachment, and passive suicidal ideation “for as long as I can remember,” but denies active suicidal ideation, intent, or plan. Denies history of suicide attempts. Reports history of nonsuicidal self-injurious behavior via cutting from approximately 2016–2024. When asked about PTSD symptoms such as flashbacks or nightmares, patient does not answer but discusses Germany more.

PMHx: PTSD, chronic depression/anxiety, possible bipolar disorder
Past Psychiatric History: Recent inpatient psychiatric hospitalization at Gracie Square Hospital earlier this month
PSHx: Denies
Allergies: NKDA, denies
Meds: Olanzapine 10 mg nightly, lithium 300 mg BID, estrogen therapy

Social:
Denies alcohol, tobacco, nicotine, or recreational substance use.
Lives in Bronx, NY.
History significant for multiple sexual assaults and severe trauma exposure.
Intermittently follows with outpatient therapist.
Works as bartender, part-time

ROS:
General: Endorses decreased sleep and increased energy. Denies weight loss.
Psychiatric: Positive for dissociation, racing thoughts, impulsivity, distractibility, chronic anxiety, depressed mood, passive SI, emotional detachment, and memory impairment. Denies active SI/HI. Denies auditory or visual hallucinations.
Neurologic: Positive memory impairment and concentration difficulties. Denies seizures or focal neurologic deficits.
GI: Denies nausea, vomiting, abdominal pain, or diarrhea.

Mental Status Exam:
Appearance: Appears stated age, appropriately groomed with adequate hygiene
Gait: Normal
Behavior: Cooperative, engaged, maintains good eye contact
Psychomotor: Within normal limits, no abnormal or involuntary movements noted
Speech: Spontaneous, articulate, mildly hyperverbal with mildly increased rate, normal volume
Thought Process: Mostly goal directed with intermittent tangentiality, redirectable
Thought Content: Passive SI without intent or plan. Describes dissociative identity framework organized around “Germany.” Mild grandiose themes present
Mood: “My life is pain”
Affect: Flat, restricted, congruent with mood
Perception: Denies auditory or visual hallucinations. Does not appear internally preoccupied
Attention/Concentration: Mildly impaired at times but overall attentive during interview
Suicidality: Endorses chronic passive SI. Denies active SI, plan, or intent
Homicidality: Denies homicidal ideation, plan, or intent

Insight: Fair
Judgment: Fair
Impulse Control: Fair

Assessment:

24 y/o transgender female with PMHx of PTSD, chronic trauma exposure, and recent psychiatric hospitalization for possible bipolar disorder presenting for intake evaluation due to ongoing dissociation, insomnia, racing thoughts, increased energy, and passive suicidal ideation. Patient's presentation is notable for extensive dissociative symptoms, identity fragmentation, memory gaps, and symbolic internal identity organization suggestive of trauma-related dissociation. Differential includes dissociative identity disorder or other specified dissociative disorder, particularly given severe trauma history and chronic dissociative symptoms. Also consider Bipolar I disorder, current manic or mixed episode, given decreased need for sleep, racing thoughts, increased energy, distractibility, impulsivity, and mild grandiosity. Psychotic-spectrum illness considered less likely at this time as patient maintains overall reality testing and denies hallucinations.

DDx:

Dissociative Identity Disorder (DID)

- DSM-5 requires 2+ identity states, memory gaps, distress/impairment, and not due to substances or culture
- Patient reports long-term identity fragmentation ("parts system" since ~2016–2017), significant memory gaps, and chronic dissociation. Symptoms are persistent and linked to trauma history, which supports DID
- Patient also knows this is a symbolic framework and not literal reality, which argues against psychosis

PTSD with dissociative features

- DSM-5 PTSD requires trauma exposure + symptoms like intrusion, avoidance, mood changes, and hyperarousal >1 month.
  Patient has severe trauma history, anxiety, insomnia, emotional numbness, and dissociation. Symptoms fit PTSD, but severity and identity fragmentation may be beyond typical PTSD

Other Specified Dissociative Disorder

- Used when dissociation is present but full DID criteria are not met
- Patient has dissociation, identity disturbance, and memory issues, but it is unclear if there are clearly separate identity states with full amnesia between them

Bipolar I Disorder (manic or mixed episode)

- Fits the DSM-5 criteria of mania with at least 1 week of increased energy and decreased need for sleep plus symptoms like racing thoughts, distractibility, or grandiosity
- Patient reports decreased sleep, increased energy, racing thoughts, and mild grandiose ideas

- However, symptoms are mixed with trauma/dissociation and no clear prior manic episodes, so diagnosis is not confirmed

Borderline Personality Disorder traits

- DSM-5 includes unstable identity, mood swings, self-harm, and chronic emptiness
- Patient has chronic SI, history of cutting, identity disturbance, and emotional instability
- However, symptoms may be better explained by dissociation/trauma rather than primary personality disorder

Plan:

Continue olanzapine 10 mg nightly
Increase lithium to 300 mg every morning and 600 mg nightly
Start trazodone 50 mg nightly PRN insomnia
Obtain CBC, BMP, hepatic function panel, TSH, and lithium level
Refer for outpatient psychotherapy with trauma-focused therapy emphasis
Referral to LGBTQ+/Pride clinic services
Safety planning completed due to passive suicidal ideation
Return to clinic in 3 weeks for continued intake evaluation and diagnostic clarification