

The Mental Status Exam

The Mental Status Exam (MSE) is a standard part of any psychiatric interview. It is a description of clinical observations of a patient's current emotional state and mental functioning. Much of the information is obtained in the course of the interview through informal observation. There are aspects that need formal questioning. The data obtained in the MSE will help in the process of making a diagnosis and treatment plan as well as help provide a baseline for future reference.

As a medical student in your psychiatric clerkship, you are strongly encouraged to document a MSE in your progress notes as well as in all initial evaluations or consultations. Your challenge is to make the MSE as descriptive as possible. Remember, documenting a patient's behavior or thought process as "good" or "within normal limits" is not very descriptive. You will also find it will bore you to tears and do little to impress those who read and evaluate your writings. Work at the descriptions as it will make the MSE more interesting and will help you train this aspect of your powers of observation.

This handout design is intended to help you learn about the MSE's components, the various ways to describe different aspects of the MSE, as well as what the diagnostic considerations may be for various findings.

Mental Status Exam Sections

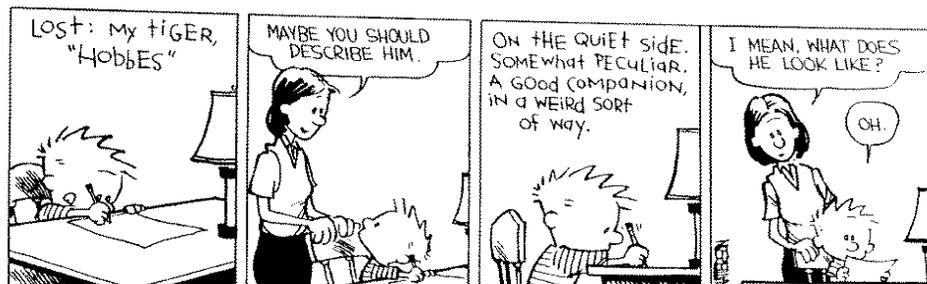
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|---------------|--------------------|-------------|
| 1. Appearance | 5. Speech | 9. Judgment |
| 2. Behavior | 6. Thought Process | 10. Insight |
| 3. Mood | 7. Thought Content | |
| 4. Affect | 8. Cognition | |

Setting of the Interview

- Hospital room, Waiting room, Out-patient clinic office, Emergency Room
- Season, Time of Day

1. Appearance

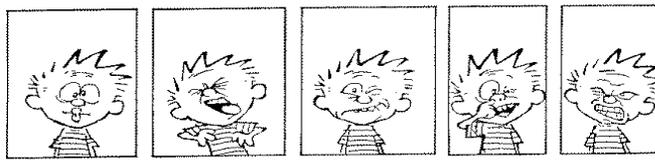
Is it Appearance or Behavior? General Guideline: If you can capture it in a photo it's appearance. If you need a movie it's a behavior.



In describing appearance consider including:

- **general**-gender, stated age, appears stated age, appears older/younger than stated age
- **body type**-endomorph, ectomorph, mesomorph, thin/skinny/underweight, muscular/lean, obese/overweight/stocky
- **clothes**- suit, button down shirt & tie, dress pants; sweater, sweatshirt, t-shirt, jeans, shorts, blouses, dress/skirt; shoes, boots, heels, sandals; hospital gown; colors, patterns; clean, dirty; worn, tattered, frayed, stained; mismatched clothes (plaid pants & striped shirt?)
- **grooming/hygiene**-body odor, odor of urine or feces, perfume/cologne, clothes clean or soiled, food stains on the bib area of shirt?, clothing torn or frayed

- **hair**-short/long/balding/completely bald, clean, dirty, matted, styled/perm, curly/straight, pulled back from face? hides face? lanugo hair?
- **facial hair**-mustache, beard, goatee, unshaven/clean shaven
- **make-up**-carefully/carelessly done, excessive/overdone
- **nails**-manicured, dirty, thickened, nail polish
- **I.D markings**-missing teeth, scars, bruises, tattoos (where on body, what is tattoo), body piercing(s), jewelry/rings/bracelets, necklaces, earring(s)
- **Facial expression**-could be part of appearance if mainly/only one expression; smiling, blank, scowling, smirking, blushing, on verge of tears/tearful/crying
Could be part of behavior if facial expression changes during interview;
Helpful to include the facial expression with the context of the interview:
 Scowling while describing how family insisted he get help;
 Blushing when discussing behaviors during her manic episode;
 Smirking when answering questions about having suicidal thoughts;



- **Eye contact**-as with facial expression, could be part of appearance if mainly only one description:
 Staring, downcast gaze, avoiding eye contact, staring through interviewer
Could be part of behavior if it noticeably changes during interview: Intermittent, irregular, shifty

Examples of Diagnostic Considerations from Appearance

- **Major depression**-poor grooming, poor hygiene
- **Anorexia Nervosa**-decreased body weight, baggy clothes, lanugo
- **Substance Use Disorder**- poor grooming, poor hygiene
 IV drug use/dependence-needle marks/tracks, clothing to hide the needle marks
 Marijuana abuse-sunglasses, injected conjunctiva of eyes
 Alcohol dependence-arcus senilis, bruising, palmar erythema, spider angiomas
- **Manic, Histrionic personality**-excessive make-up, jewelry, brightly colored clothing
- **Trichotillomania**-patchy areas of hair loss; no eyebrows
- **Dementia**-poor grooming, food stains on bib of clothes, body odor

2. Behavior

Behavior descriptions would include mention of the patient's psychomotor level (their movements or lack of) and attitude toward interviewer (how you felt the patient related to you).

Psychomotor level

- **Movements**-(Is patient agitated?--work on a more specific description):
tapping foot, shifting in chair, rocking, squirming, hand gesturing, hand wringing, drumming fingers, unable to sit/has to stand, pacing around the room, chewing, nail biting
 - **Involuntary movements or mannerisms**-aimless/purposeless, grimacing, tics, twitches, picking, blinking, lip smacking, hand tremor, stereotyping (an isolated, purposeless movement performed repetitively), echopraxia (repetitive imitation of movements of another person), asterixis
- **Calm**-sitting quietly, any spontaneous movements? no spontaneous movements?, slowed movements, catatonic, paraplegic/hemiplegic/quadruplegic
- **Posture**-relaxed, rigid, tense, hunched over, stooped, bizarre, slouched, relaxed, stiff, erect

Attitude toward interviewer

- appropriate, cooperative, compliant

- defensive, aggressive, manipulative, demanding, hostile, threatening
- passive/submissive, disinterested, aloof, withdrawn, evasive,
- seductive, provocative, condescending, arrogant, patronizing
- suspicious, frightened, puzzled

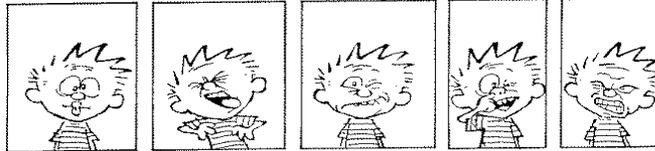
Facial expression-(may or may not be related to attitude toward interviewer); smiling, blank, scowling, smirking, blushing,

May vary depending on context of the interview, so may want to add contextualization:

Scowling while describing how family insisted he get help;

Blushing when discussing behaviors during her manic episode;

Smirking when answering questions about having suicidal thoughts:



Eye contact-intermittent, irregular, staring at interviewer, staring through interviewer, shifty, avoidant, wearing sunglasses, scanning

Diagnostic Considerations of Behavior

- **Major depression**-psychomotor retardation or agitation, withdrawn
- **Manic**-demanding, provocative, seductive, restless, distractible
- **OCD**-repetitive behavior
- **Generalized Anxiety Disorder**-muscle tension, fidgety, sweaty palms
- **Anti-Social Personality**-calm, glib, manipulative, demanding
- **Schizotypal Personality**-odd, eccentric, peculiar behavior
- **Schizophrenia negative symptoms**-disinterested, withdrawn,
- **Psychotic**-scanning the room (paranoid?), unidentifiable distractions/responding to internal stimuli (hallucinations?)
- **Psychotropic medication side effects:**
 - tremor (Ex. Lithium, Depakote, Parkinsonism from dopamine blocking medication)
 - rhythmic athetoid and/or choreiform movements (Tardive Dyskinesia)
 - restlessness/akathisia (Ex. from dopamine blocking medication)
 - muscle spasms/abrupt stiffness (dystonia from dopamine blocking medication)

3. Mood

Mood is a pervasive and sustained emotion that colors the perception of the world. Common examples of mood include depression, elation, anger, and anxiety. In contrast to affect, which refers to more fluctuating changes in emotional "weather", mood refers to a pervasive and sustained emotional "climate".

So you ask the patient "How have you been doing recently?" or "How has your mood been recently?" The patient may say their mood is good or happy. Or may say their mood is sad or depressed. The patient answered and now you have the mood.

Types of mood include:

- **Dysphoric**-an unpleasant mood, such as sadness, anxiety, or irritability
- **Elevated**-an exaggerated feeling of well being, or euphoria or elation. A person with elevated mood may describe feeling "high", "ecstatic", "on top of the world", or "up in the clouds"
- **Euthymic**-mood in the "normal" range, which implies the absence of depressed or elevated mood
- **Expansive**-lack of restraint in expressing one's feelings, frequently with an over-valuation of one's significance or importance

- Irritable-easily annoyed and provoked to anger

Other descriptive terms often used

- good/happy; sad/depressed; angry/hostile; anxious/apprehensive/nervous
- alexithymia-patient incapable of describing mood

4. Affect

A pattern of observable behaviors that is the expression of a subjectively experienced feeling state (emotion). Examples of affect include sadness, elation, and anger. In contrast to mood, which refers to a pervasive and sustained emotional "climate," affect refers to more fluctuating changes in the daily emotional "weather".

During the interview you will "connect" to some extent with the patient just as you would in talking with anyone. As you connect you can better sense the other person's emotions. You will notice the range or variability of affect shown during your interaction with them. You will sense happiness, sadness, irritableness, impatience, tolerance, anger, and more. In assessing the patient's affect, you will also want to notice the various cues to the patient's emotional state. This includes eye contact, facial expression, body posture, speech qualities, hygiene and grooming. (You will be describing a number of these cues in the appearance & behavior part of the MSE) You also want to notice how the patient's cues vary or do not vary with the content of their story (appropriateness, congruence).

Typically it is useful to describe 4 components of affect:

- 1) **State:** your assessment of the pts current emotional state (dysphoric, euthymic, euphoric, irritable, anxious, etc.)
 - Guarded-very similar to restricted (below), but you feel the other person is attempting to **hide** their emotions from you
- 2) **Range:** describes the variance of the state within the interview
 - Full-range of emotional expression is what is typically seen in a "normal" person. Note, what is considered the normal range of the expression of affect may vary considerably, both within and among different cultures.
 - Restricted or Constricted-mild reduction in the range and intensity of emotional expression
 - Blunted-significant reduction in the intensity of emotional expressions
 - Flat-absence or near absence of any sign of affective expression
 - Labile-abnormal or more extreme variability in affect with repeated, rapid, and abrupt shifts in affective expression
- 3) **Appropriateness:** Is the affect appropriate to the thought content and contextual elements?
 - Tearful when discussing something sad or upsetting; laughing at something funny
 - Inappropriate - discordance between affective expression and the content of speech or ideation; laughing when discussing death, being overly familiar/excessively jocular/flirtatious with the interviewer, etc.
- 4) **Congruence;** is the affect congruent with stated mood?
 - Mood is "good" or "fine" despite ongoing tearfulness throughout interview

Diagnostic Considerations of Mood & Affect

- **Mania**-classic presentation is an elevated/expansive mood and a labile range of affect
- **Borderline Personality**-DSM5 criteria-chronic feelings of emptiness; affective instability with dysphoria, irritability, anxiety (labile range of affect?); intense anger;
- **Delirium**-may see a labile range of affect (hyperactive delirium); may also see a blunted range of affect (hypoactive delirium)
- **Major depression**-may see restricted, constricted, or guarded affect
- **Schizophrenia**-classically a blunted or flat affect is observed

5. Speech

Various qualities of speech to describe include:

- **Clarity**-clear, slurred, coherent, accent present, mumbles, stutters, stammers, garbled
- **Rate**-slow, relaxed/conversational, rapid, pressured
- **Quantity**-talkative, verbose, increased, pressured, minimal, decreased, mute
- **Tone**-monotonous, flat, increased/decreased inflection, sullen, irritated, animated, excited, expressive, emphatic



- **Flow**- spontaneous, hesitations, pauses, word finding difficulties, delayed response, latency, deliberate, methodical, fluent, non-fluent
- **Volume**-whispered, soft/quiet, low, conversational, loud/yelling
- **Other descriptive terms for Speech**
 - **Dysarthric**-slow and slurred speech
 - **Pressured speech**-increased in quantity, accelerated, and difficult-to-impossible to interrupt. A person with pressured speech will verbally run you over in a very one sided conversation. Usually the speech is also loud and emphatic. Frequently the person talks without any social stimulation and may continue to talk even though no one is listening;
 - **Fluency**-ability to produce sentences of normal length, rhythm, and prosody; For clinical purposes a patient is either fluent or non-fluent;
 - **Prosody**-reflection of emotion in speech typically created by the combination of rate, volume, and tone

Diagnostic Considerations of Speech

- **Mania**-classically pressured speech; or not quite pressured but rapid and increased quantity
- **Anxiety disorder**-increased quantity, rapid speech
- **Depression**-decreased quantity, soft, monotone or decreased prosody/inflection
- **Schizophrenia**- decreased quantity; monotone or decreased prosody/inflection, non-spontaneous, increased latency

6. Thought Process

Thought process describes the associations between thoughts. Does the person you are interviewing make sense? Does the patient answer your questions and get to the point? Do they ramble? Are you unable to follow their responses at all?

Associations

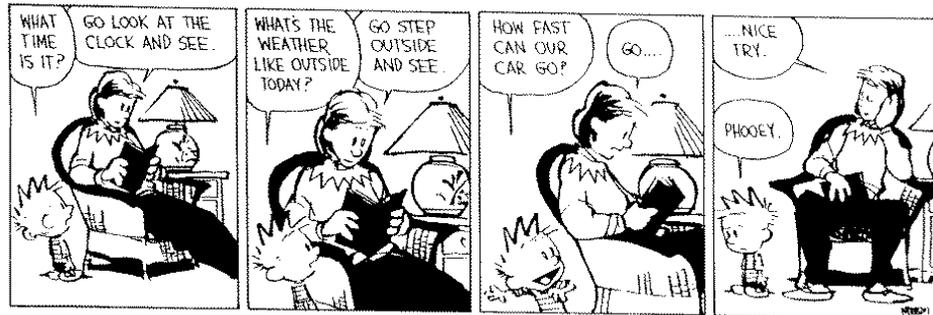
- **logical and sequential/goal-directed**-the patient answers the question or tells a story that goes from topic to topic, point to point in a way that makes sense; words and sentence structure are clear; linkage between ideas are clear
- **circumstantial**-over inclusive of details that are irrelevant or marginally relevant to the point (perhaps you know someone like this);

- **tangential**-does not directly address the point or never finishes the original point; talks about topics brought to mind by internal or external stimuli; words/sentences/ideas are understandable;
- **flight-of-ideas**-a nearly continuous flow of accelerated speech with abrupt changes from topic to topic that are usually based on understandable associations, distracting stimuli, or plays on words. When the condition is severe, speech may be disorganized and incoherent; As a listener you may be able to follow the changes and see the connections or theme that links the topics; often seen with pressured speech.
- **looseness of associations**-connection between ideas is not obvious, unclear or nonsensical; as a listener you cannot follow the topic changes or even make out the topics the patient is talking about; substantially impairs effective communication
 - **fragmentation**-words and individual phrases are intact but the phrases are disconnected making sentences and ideas meaningless
 - **word salad**-words are intact, but all sentence structure lost, including phrases
 - **incoherence**-unintelligible words; no phrases or sentence structure;

Rate or Flow

Thought process also describes the rate or flow of ideas. This is particularly noticeable when abnormal.

- **racing thoughts**-patient's thoughts are so fast that he can't articulate them or keep up with them; like watching 2 or 3 television programs simultaneously; often seen together with flight-of-ideas
- **perseveration**- repetition of verbal responses despite changing questions



- **thought blocking**- interruption of the train of thought before completion of the idea; may see momentary disruption of speech; words and sentences otherwise intact
- **derailment**-speech stops suddenly and then restarts having shifted to another topic

During your assessment, remember that patient's thought process is usually not 100% one way the entire time. Proportionally, if a patient is logical and sequential about 75% of the time and tangential about 25% of the time you might document: "thought process-mostly logical and sequential, some tangentiality."

Diagnostic Considerations of Thought Process

- **Schizophrenia**-may see derailment, looseness of association, fragmentation, word salad, incoherence (if severe)
- **Mania/hypomania**-racing thoughts, flight-of-ideas
- **Delirium**-any disorder in thought process
- **Dementia**-errors in word choice and grammar,

7. Thought content

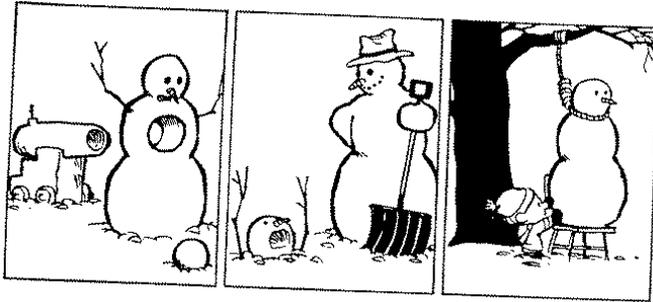
Involves what is the patient thinking about. Specifically, areas of concern include:

A. Suicidal ideation	D. Hallucinations
B. Homicidal ideation	E. Obsessions & Compulsions
C. Delusions	F. Feelings of derealization & depersonalization

A. Suicidal ideation:

- **Thoughts of death**-thinks about what it would like to be dead, the implications, funeral plans.
- **Passive ideation**-wishes he could go to sleep and not awaken; wishes he were dead or that God would call him home
- **Active ideation**-wants to die, preferably today with or without a specific plan (the details would be in the HPI)

B. Homicidal ideation:



Thoughts of death-thinks about killing or hurting another; the implications;
Active ideation-wants to kill another person, preferably today
With or without a specific plan (the details would be in the HPI);

C. Delusions

A false belief based on incorrect inference about external reality that is firmly held despite what almost everyone believes and despite what constitutes incontrovertible and obvious proof or evidence to the contrary. The belief is not ordinarily accepted by other members of the person's culture or subculture (it is not an article of religious faith). For instance, a person from Haiti may believe in the power of voodoo curses and not be considered delusional; a white, middle class person from Chicago who is not part of the Haitian culture/subculture who believed a voodoo curse had been put on them would be considered delusional.

When a false belief involves a value judgment, it is regarded as a delusion only when the judgment is so extreme as to defy credibility. Delusional conviction can sometimes be differentiated from an overvalued idea (in which case the individual has an unreasonable belief or idea but does not hold it as firmly as is the case with a delusion).

Delusions are subdivided according to their content. Some delusion categories include:

- **persecutory/paranoid**-most common delusion in which the central theme is that one (or someone to whom one is close) is being attacked, harassed, cheated, persecuted, or conspired against.
- **referential**-a delusion in which events, objects, or other persons in one's immediate environment are seen as having a particular and unusual significance. (Cubs lost, that's the signal for me to evacuate because the alien invasion is beginning!). These delusions are usually of a negative or pejorative nature but also may be grandiose in content. A delusion of reference differs from an **idea of reference**, in which the false belief is not as firmly held nor as fully organized into a true belief that random events are of some special significance.
- **grandiose**-a delusion of inflated worth, power, knowledge, identity, or special relationship to a deity or famous person, patient believes they have some great, unrecognized talent, insight, they have made some great discovery (eureka, cold fusion! unlimited energy source), or have a special relationship to a famous person
- **jealousy**-a delusion that one's sexual partner is unfaithful
- **erotomaniac**-a delusion that another person, usually of higher status, is in love with the individual
- **somatic**-involves bodily functions or sensations

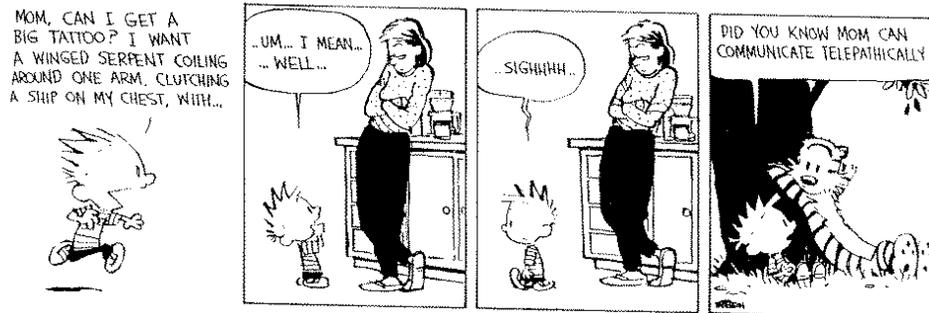
- **bizarre**-a delusion that involves a phenomenon that the person's culture would regard as physically impossible.

Examples:

Thought withdrawal-belief that other people are taking away one's thoughts

Thought insertion-a delusion that certain of one's thoughts are not one's own, but rather are inserted into one's mind

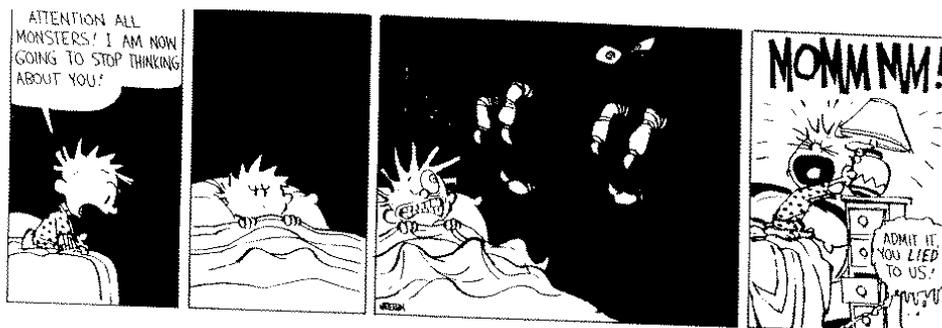
Thought broadcasting-a delusion that one's thoughts are being broadcast out loud so that they can be perceived by others.



Delusion of control-a delusion in which feelings, impulses, thoughts, or actions are experienced as being under the control of some external force rather than being under one's own control

D. Hallucinations

- **Auditory**-false perceptions of sound must be experienced in a clear sensorium; so if a patient says the hallucinations woke him up from sleeping, ask more questions
 - **command auditory hallucinations**-a force against the patient's own wishes, best interests, or safety; can patient resist the commands?
 - **hypnagogic**-auditory or visual perceptions experienced while falling asleep; not abnormal (mnemonic-"go"= go to sleep)



- **hypnopompic**-auditory or visual perceptions experienced while waking up; not abnormal (mnemonic-"m"= morning)
- **Visual**-false visual perceptions
- **Tactile**-false perceptions of touch;
 - **Formication**-feeling of bugs crawling under one's skin
- **Olfactory**-false perceptions of smell
- **Gustatory**-false perceptions of taste
- **Illusions**-a misperception or misinterpretation of a real stimuli, such as hearing the rustling leaves as the sound of voices; misperceptions of environmental stimuli; a shadow is mistaken for an object; these are not hallucinations
- **Hallucinosi**s-patient know that what he sees or hears is not real; sort of like having insight into one's hallucinations; some refer to this as pseudohallucinations

E. Obsessions & Compulsions

- **Obsessions**-persistent ideas, thoughts, impulses, or images that are experienced as intrusive and inappropriate and cause marked anxiety and distress; the individual feels they "just have to" think these thoughts. Most common obsessions are about: contamination, self-doubt, orderliness, sexual imagery, aggressive/horrific impulses,
- **Compulsions**-repetitive behaviors (hand washing, ordering, checking) or mental acts (praying, counting, repeating words silently) that the individual feels driven to perform in response to an obsession, or according to rules that must be applied rigidly. The behaviors or mental acts are aimed at preventing or reducing anxiety or distress, or preventing some dreaded event or situation; however, these behaviors or mental acts are not connected in a realistic way with what they are designed to neutralize or prevent or are clearly excessive.

F. Feelings of derealization & depersonalization

- **Derealization**-the experience of feeling detached from, and as if one is an outside observer of, one's surroundings (individuals or objects are experienced as unreal, dreamlike, foggy, lifeless, or visually distorted).
- **Depersonalization**-the experience of feeling detached as if one is an outside observer of one's mental processes, body, or action (feeling like one is in a dream; a sense of unreality of self, perceptual alterations; emotional and/or physical numbing; temporal distortions; sense of unreality) Derealization and depersonalization typically occur together and may be different aspects of the same phenomenon.

Diagnostic Considerations of Thought Content

- **Alcohol withdrawal**-hallucinoses
- **Cocaine intoxication**-formication delusion, insects are crawling on or under the skin
- **Schizophrenia, Schizophreniform disorder, Schizoaffective disorder, Brief Psychotic disorder, Mood disorder with psychosis, Dementia, Delirium**- delusions, hallucinations
- **Delusional disorder**-delusions
- **Obsessive Compulsive Disorder**-obsessions and compulsions
- **Obsessive Compulsive Personality**-preoccupation with rules, order, organization such that the point of the activity is lost
- **Post Traumatic Stress Disorder**-recurrent and distressing thoughts/memories (flashbacks) of the event; derealization, depersonalization
- **Paranoid Personality**-suspicion others want to harm him; preoccupied about other's loyalty
- **Schizotypal Personality**-odd beliefs, suspiciousness or paranoid ideas

8. Cognition

May be assessed in the course of the interview (the patient's responses indicate the patient is oriented, the memory is intact, etc.) or may be more formally assessed by going through the Mini Mental Status Exam (MMSE).

Oriented x 4

- **person**-need to ask if patient knows the people around them; only in the most severe instances will the patient not know who they are
- **place**-in addition to knowing where they are, does the patient behave as though he knows where he is
- **time**-can patient give the approximate date and time of day; does the patient behave as though he is oriented to the present?
- **situation**-does the patient behave as if he is oriented to place and time; oriented to purpose of the interview; also deals with the patient's level of insight

- **level of consciousness-**
 - **sedated, groggy, or drowsiness**-sleeplike state from which the patient cannot be fully aroused by minor stimuli like a spoken request
 - **clouding**-impaired awareness of the environment
 - **stupor**-vigorous and repeated stimulation is required to rouse the patient
 - **somnolence/lethargy**-drowsy, inactive, indifferent patients respond in delayed or incomplete manner
 - **coma**-neither verbal nor motor responses can be elicited by noxious stimuli (obviously this will limit any formal questioning in the MSE)

Concentration & Attention-serial 7's calculations or spell world/earth forwards and then backwards
Memory

- **Recent memory**-can patient recall recent news events from past few months
- **Remote memory**-can patient recall childhood data, important events known to have occurred, personal matters; verification by interviewer needs to be done
- **Recall**-able to recall the 3 unrelated words 3-5 minutes later; Ex. apple, honesty, star rather than apple, cider, red



Abstract thinking-can patient interpret proverbs, similarities & differences (how are a bush and a tree alike and different) or is his thinking concrete in which words and figures of speech are taken literally

General Fund of Knowledge- name 5 past presidents, 5 large cities, 5 sports teams, etc.; need to take into account the patient's educational level

Folstein Mini-Mental State exam-series of questions and simple cognitive tasks that can be done at the bedside; scored out of 30 (See separate handout)

Also assessment options: SLUMS and MOCA

Diagnostic Considerations of Cognition

- **Delirium**-disorientation to situation, time and place; rarely to person; very poor concentration; serial MMSE testing encouraged
- **Dementia**-memory impairment, poor abstract thinking, apraxia, agnosia
- **Substance Intoxication**-decreased alertness, disoriented, poor concentration
- **Major Depression**-poor concentration, indecisive
- **Manic/Hypomanic**-distractible/poor concentration
- **Korsakoff syndrome**- anterograde amnesia (poor or variable short term memory)

9. Judgement

Current/recent ability to assess a situation correctly and to act appropriately within that situation; or current/recent ability to make and carry out plans that are consistent with reality.

So you are looking at patient's recent choices/decisions

A patient plans to acquire a gun to shoot himself in the head. The patient's judgment would be assessed as "poor" because society does not consider suicide as an appropriate action.

A patient believes he has formication of insects under his skin and contacts an exterminator to help him get rid of the bugs. This is not consistent with reality that there are not actually insects under the patient's skin. Psychosis very often leads to poor judgment.

Can the patient predict what he would do in an imaginary situation?

Questions that are frequently taught to be asked are imaginary situations such as "If you were in a crowded movie theater and smelled smoke what would you do?"

While asking about hypothetical situations may be helpful, it is more relevant to ask the patient what he would like to do, or to have done, in his current situation that has resulted in you interviewing him.

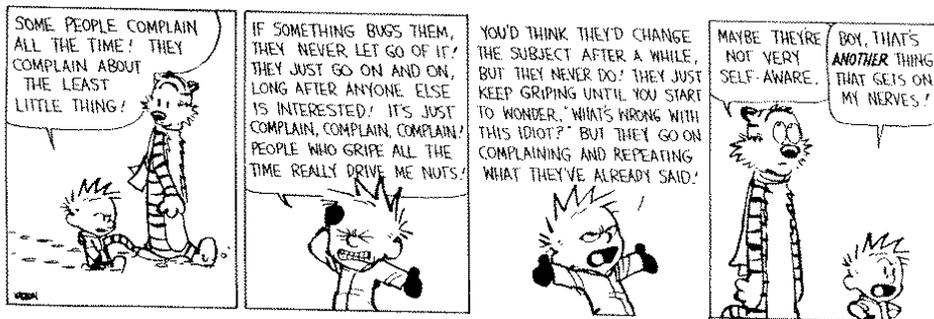
10. Insight

Understanding of the true cause and meaning of a situation (such as their symptoms or illness).

Worded another way, to what degree does the patient understand that they are ill?

A patient's insight may vary:

- Complete denial of illness
 - May acknowledge but blame their situation (their illness symptoms) on others, on external factors, or on organic factors
- Partial awareness of being sick and needing help but denying it at the same time
 - Awareness of being sick but being unable to apply this awareness in a useful way. This may be referred to as having **Intellectual Insight**.
- True or full Insight
 - Understanding of the objective reality of a situation, coupled with the motivation and the emotional impetus to master the situation.
 - Patient understands they are ill and is working to apply this awareness to make useful behavioral changes



Judgement and Insight are often described as being: good/intact, fair/partial, or poor/impaired.

Adding a brief explanation is encouraged.

- Remember to consider current **and** recent events.
If a patient made a suicide attempt a few hours ago and is now in the hospital and denying SI would one say the patient's Judgement is now "good". At the very least, if you were going to say the patient's judgment is now "good" you would want to note the patient's Judgement was poor very recently as they made a suicide attempt. Same thing with Insight.

Judgement: Poor, pt is actively delusional;

Fair or Fair/poor, pt denies delusions: Pt was recently delusional.

Insight: Poor, pt stopped meds, now actively manic and refusing meds or other treatment.

Fair, pt acknowledges depression and suicidal ideation, but declines treatment as pt "just does not want treatment"

Fair, pt agrees to getting/accepting help now after involuntary admission last night

Lastly, in considering Judgment and Insight should one approach the question from the standpoint of what information may indicate the patient's Judgment and Insight are good? Or should the question be approached from the standpoint of whether there is any reason to say the patient's Judgment and/or Insight is faulty or poor?

In a psychiatry assessment the default for Judgment and Insight is that it is good or intact. In an assessment we are looking at the question from the perspective of whether there is any reason to say the patient's Judgment and/or Insight is faulty or poor. If the patient is suicidal or delusional, that one area of judgment or insight where there is a problem could result in dire consequences. So in looking at Judgment and Insight while one may want to hope for the best, we have to prepare for the worst.