# NMNEC Concept: **Mood and Affect**

**Mega Concept:** Health and Illness

**Category:** Emotional Processes

**Concept Name:** Mood & Affect

**Concept Definition:**
The way a person feels and the external expression of that feeling.

**Scope/Categories:**
The term *euthymia* is used to describe normal, healthy fluctuations in mood from sadness to happiness, but there are many other euthymic mood states, such as anger, frustration, boredom, love, hate, and joy. When any mood persistently disrupts the *functional status*, this mood state is called *dysphoria.* Dysphoria may result in moderate functional impairment by any combination of irritability, lethargy, fatigue, and agitation, or it may result in severe functional impairment by acute confusion, hallucinations, and/or delusions.

Because dysphoric moods range in a spectrum from severe melancholic depression to severe manic depression, they may be referred to as *mood spectrum disorders*, and there are many mood spectrum disorders identified in medical diagnostic models. Any of them are suitable as exemplars for this concept.

But there is some confusion in terminology brought on by the popular use of the word "depression" to describe normal (euthymic) sadness that is not persistent or severe enough to cause any significant functional impairment. However, sadness can be so overwhelming that it drains the energy and will to live so that a mood spectrum diagnosis such as Major Depression may be made by a qualified diagnostician. Paradoxically, dysphoria may also result in severe agitation, mania, and even euphoria, which do not look like sadness at all.

To avoid this confusion, students are advised to refer to affective states that are characterized by sadness, despair, and loss of functional status as *melancholy.* Psychiatric diagnosticians, such as psychiatrists and psychiatric nurse practitioners, may refer to these sad, dysphoric mood

states as *unipolar depression*. If, however, the affect is agitated and/or euphoric, it is recommended that generalist nurses refer to this affect as *mania* or *hypomania*, wherein hypomania is less severe than mania. Depending on the severity, mania and hypomania are likely to be psychiatrically diagnosed as bipolar I and bipolar II depression, respectively, formerly known as *manic depression*. Major depression, mania, and hypomania are recommended as exemplars for the Mood and Affect concept.

**Risk Factors**:

- **Populations at Risk:** Fluctuations within the euthymic (normal) range of mood and affect occur daily among all populations throughout the lifespan. The rate of major depression among women is two to three times higher than in men, and the first episode of major depression for either gender usually occurs during adolescence or early adulthood (U.S. Department of Health and Human Services [USDHHS], 2016). The incidence of depression peaks bimodally, occurring with the highest frequency during the late twenties or early thirties and again during the late sixties (USDHHS, 2016).

- **Individual Risk Factors:** Individual risk factors for major depression are stress, early trauma, neglect, abuse, family history, comorbid medical and psychiatric disorders, and personality disorders (USDHHS, 2016).

**Physiological Processes and Consequences:**

Various neuroimaging studies of mood spectrum disorders demonstrate reduced blood flow and abnormal phosphorous metabolism in the cerebral cortex and especially the prefrontal cortex. The activity of various neurotransmitters is also disturbed in mood spectrum disorders, particularly the levels of dopamine, norepinephrine, and serotonin (Cuellar, Johnson, & Winters, 2004). Interpersonal relationships and productivity may be greatly limited by functional status impairment during mood spectrum disorders. Psychosocial variables, such as negative life events, personality traits, and individual cognitive styles, are associated with mood spectrum disorders (Cuellar et al., 2004).

Patients with mood spectrum disorders are high users of medical care, and the incidence of mood spectrum disorders is increased in general medical care patients. The most ominous consequence is the increased potential for suicide (Harvard School of Medicine, 2005). Rates of suicidal ideation and attempts among individuals with mania and hypomania range between 35% and 50% (Stang, Frank & Yood, 2007). A study of more than 25,000 patients found that

patients with *undiagnosed* mania or hypomania were four times more likely to attempt suicide than those who were diagnosed (Shi, Thiebaud & McCombs, 2004).

**Assessment/Attributes:**
The defining characteristics of Mood and Affect disorders are (1) *persistent* mood disturbance, (2) functional impairment, and (3) disturbed vegetative functioning (sleep, appetite, and energy).

**Subjective and Objective:**
The assessment of mood should be based on the patient's report. Occasionally, nurses may infer mood from affect, but this can be misleading because affect is not always congruous with mood. The reason affect is not always congruous with mood is because understanding affect as the outer appearance of mood is an over-simplification of affect. In fact, mood is one component of affect and the other two components are the individual's energy and cognition (thought content). The Appendix illustrates how even though the mood (green line) cycles down and remains down in the melancholic range, the affect varies from lethargy to agitated, depending on the energy and thought content (Mackinnon and Pies as cited in Elgie, 2016). An understanding of this will greatly enhance the nurse's ability to assess mental status in general and affect in particular.

Functional impairment may be assessed by the ability to realistically solve ordinary problems of daily living, such as the maintenance of hygiene, appearance, and diet. Vegetative functioning refers to the individual's appetite, sleep, and energy levels, and the key to a useful nursing assessment of these levels is to note any significant changes because each function may be increased or decreased. Therefore, an accurate baseline history is very important for comparison.

The continuous monitoring of mental status for variance from the baseline enables the nurse to detect any significant changes that may signal a mood and affect disturbance. Appearance, motor functioning, speech, cognitive processes (perception, judgment, insight, and memory), alertness, and orientation combine to form a clinical impression of the mental status.

Minimum standards of practice to manage the potential for suicide and other violence are not well established at this time, but it has been consistently demonstrated that talking about suicidal feelings does not increase the likelihood of acting on those feelings at any age (Sun,

Long, & Boore, 2005). Therefore, any affectively unstable patient should be assessed for suicidal ideation, which is done by asking clearly and directly (Sun et al., 2005). Not all suicides are predictable, but the sudden appearance of unexplained euthymia in a person who has shown persistent affective instability (melancholy, mania, or hypomania) may be an ominous sign of an impending suicidal act. In such cases, the appearance of euthymia may result from the relief of making the decision to commit suicide. This decision may be accompanied by gift giving and other acts of farewell. Behavioral signals may warn of suicidal ideation, including writing or creating art about death; giving away prized possessions; and joking about death, dying, suicide, or leaving (Sun et al., 2005).

**Diagnostic Tests:**
Laboratory and radiologic exams are conducted to discover any physiologic etiologies for the dysphoria, such as irregularities in hormone, blood glucose, or electrolyte levels and neurovascular sufficiency.

**Clinical Management - Interdisciplinary:**
**Primary Prevention**: Health Promotion
Primary prevention measures are not well established, and efforts toward prevention focus on societal egalitarian interventions, such as reduction in poverty, racism, violence, and stress (Merry, 2007). According to systematic reviews (Merry, 2007), programs that target prevention of mood disorders have been shown to reduce the severity of symptoms, but these programs tend to be early interventions rather than true prevention programs. Similar systematic reviews of universal prevention programs showed them to be ineffective.

**Secondary:** Screening
The U.S. Preventive Services Task Force (2016) recommends screening for depression in the general adult population, including pregnant and postpartum women. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.

**Tertiary Prevention:** Prevention of Disease Progression
Collaborative care for mood spectrum disorders consists of psychotherapy and/or pharmacotherapy and/or brain and vagus nerve stimulation therapies (e.g., electroconvulsive therapy). There are many types of psychotherapy, but no particular therapy has been found to be more effective than any other, and long-term outcomes of pharmacotherapy versus

psychotherapy are similar (Thase, 2003). However, relapse rates appear to be lower in psychotherapy following termination of treatment (National Institute of Mental health, 2010). Generally speaking, antidepressants are prescribed to treat patients diagnosed with unipolar depression (melancholy), and mood stabilizers are used to treat diagnoses associated with bipolar depression (mania and hypomania). Subcategories of antidepressants include the selective serotonin reuptake inhibitors (SSRIs), the norepinephrine-dopamine reuptake inhibiters (NDRIs), the tricyclic antidepressants (TCAs), the serotonin-norepinephrine reuptake inhibitors (SNRIs), and the monoamine oxidase inhibitors (MAOIs). The mood stabilizers are either lithium or antiepileptic drugs (AEDs), and numerous antipsychotic medications also have been approved as mood stabilizers.

**Interrelated Concepts:**

- Behavior - Mood and affect will have variable effects on behavior.
- Cognition – Mood and affect may have mild to severe effects on cognition.
- Functional status – Functional status may be decreased with impaired mood and affect.
- Grief – Grief is a normal affective response to loss.

**Exemplars:**

**New Mexico Nursing Education Consortium (NMNEC) Required Exemplars:**

- Suicide - Suicide is a National Patient Safety Goal and has a high incidence and prevalence.
- Major Depression – Has a high incidence and prevalence.
- Mania and Hypomania – Have a high incidence and prevalence.
- Postpartum Depression – Have a high incidence and prevalence in postpartum period.

**Optional Exemplars:**

- Unipolar Mood Disorders
    - Dysthymic depressive disorder
    - Major depressive disorder
    - Psychotic depression
    - Situational depression
- Bipolar Mood Disorders
    - Bipolar I
    - Bipolar II

- Cyclothymia

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**Resources:**

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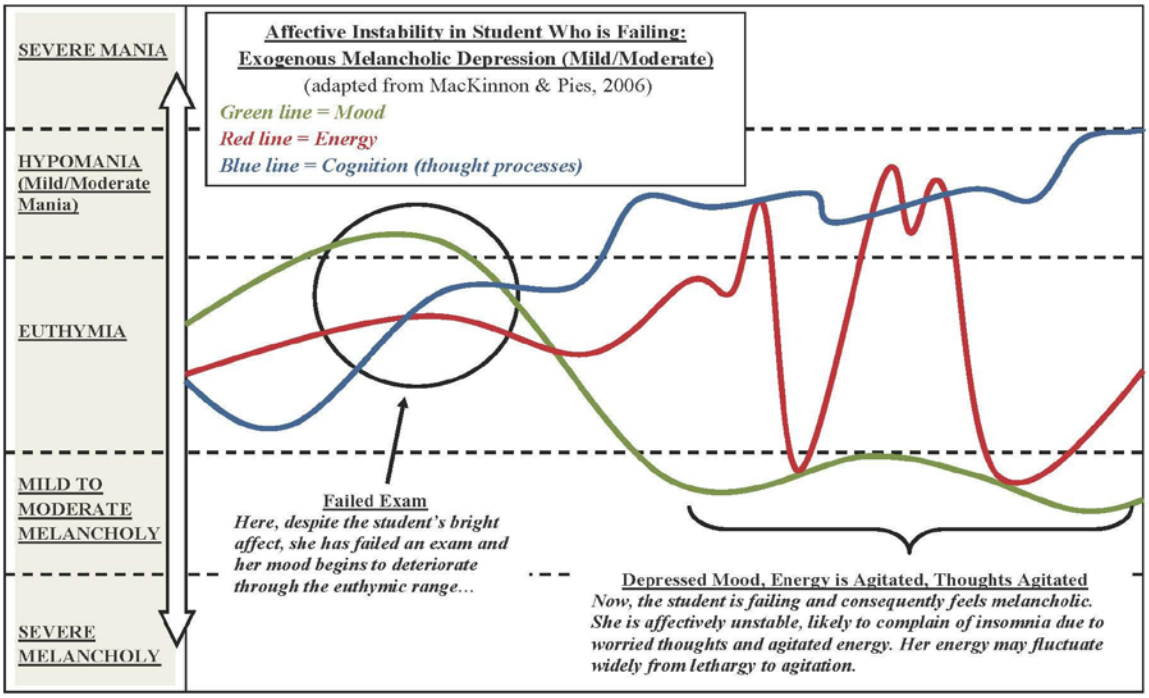
**Appendix 1**




Source:

Mackinnon, D. F., & Pies, R. (2006). Affective instability as rapid cycling: Theoretical and clinical implications for borderline personality and bipolar spectrum disorders. *Bipolar Disorders, 8*(1), 1-14. doi:10.1111/j.1399-5618.2006.00283.x