Congresso ONDA,
Milano 19 settembre 2018

Stress, ansia e irascibilità nella donna dopo l'età fertile

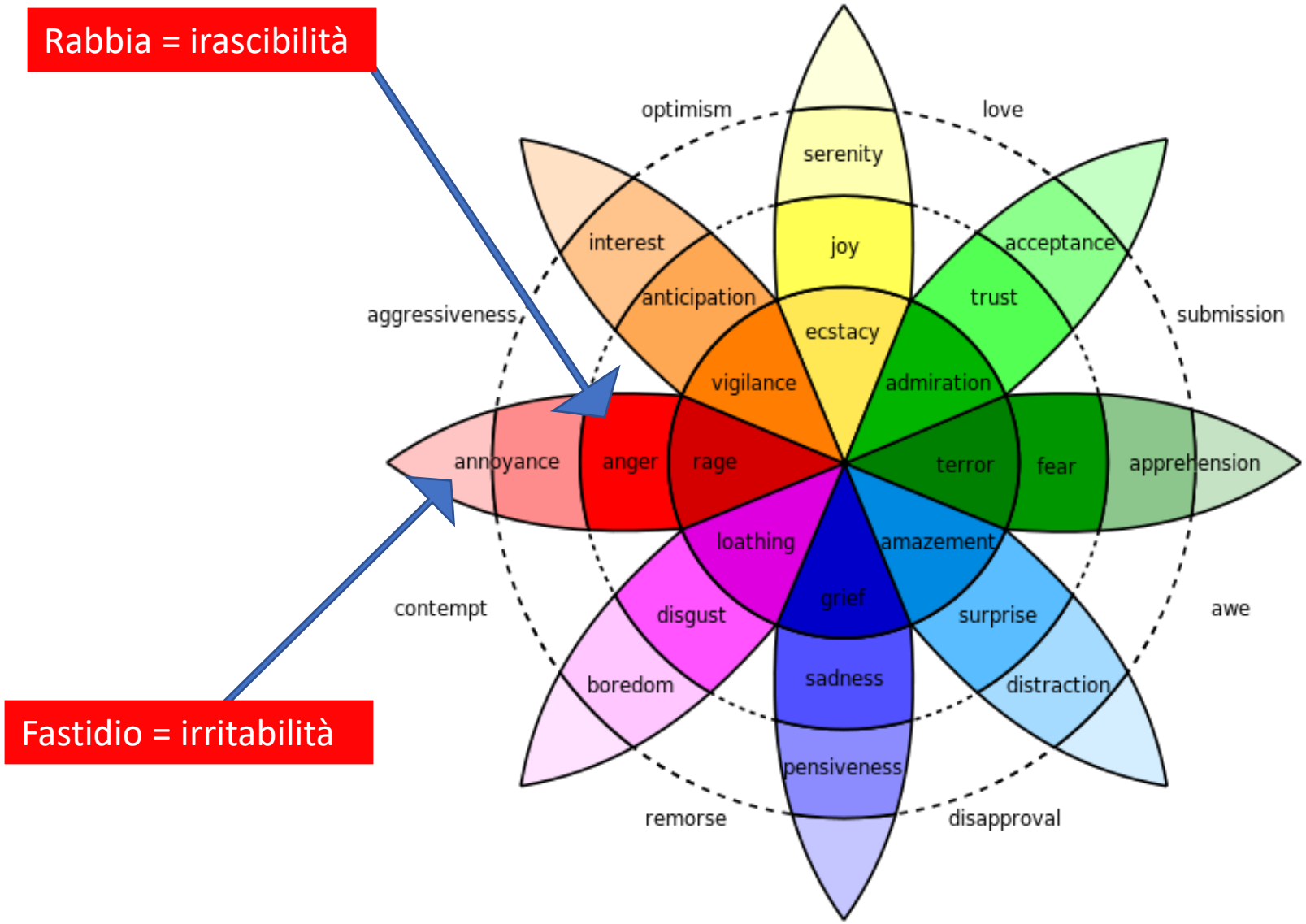
Matteo Balestrieri

Università di Udine

15 min

Irascibilità: che tipo di sentimento è?

Rabbia = irascibilità

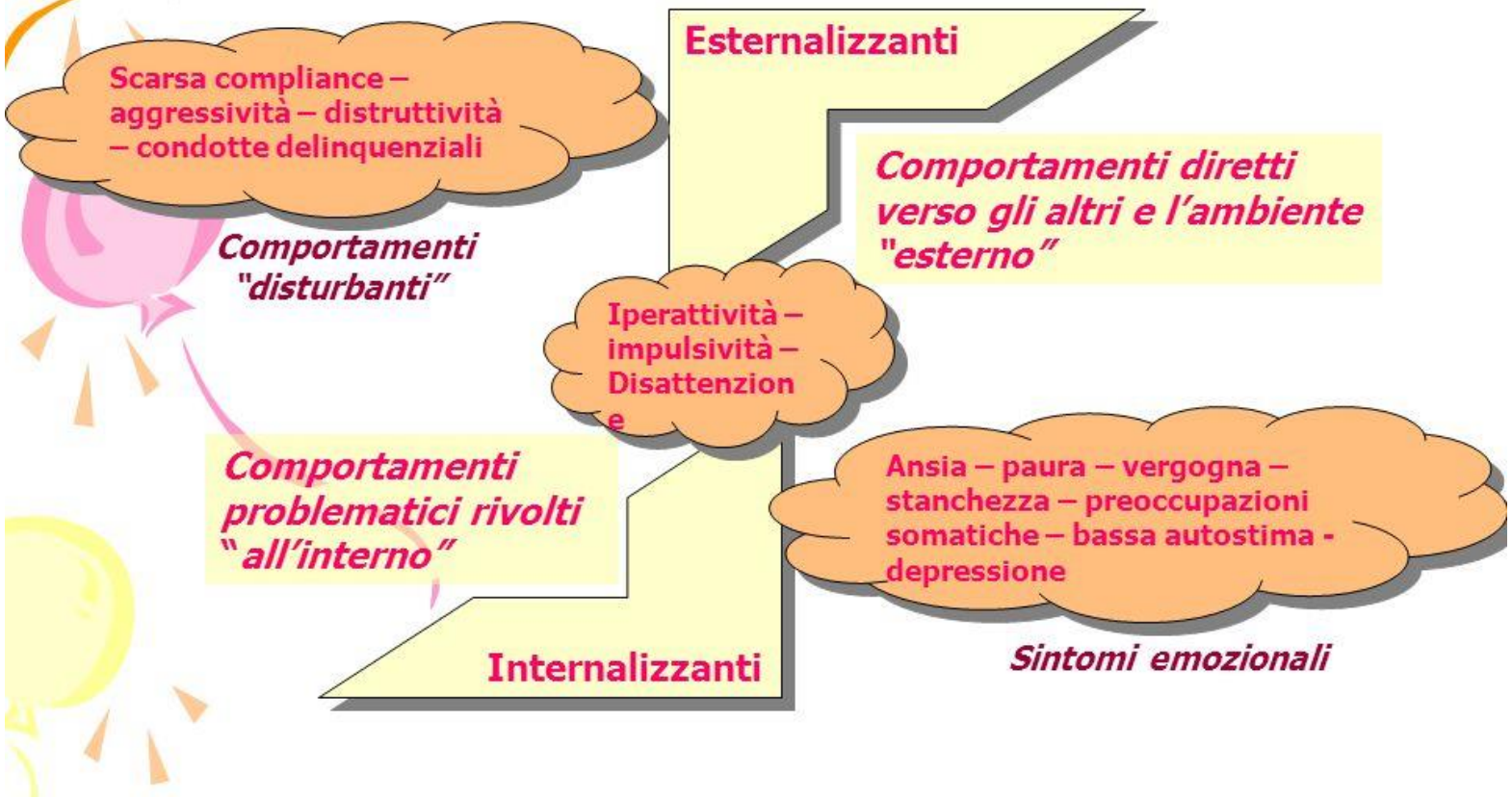


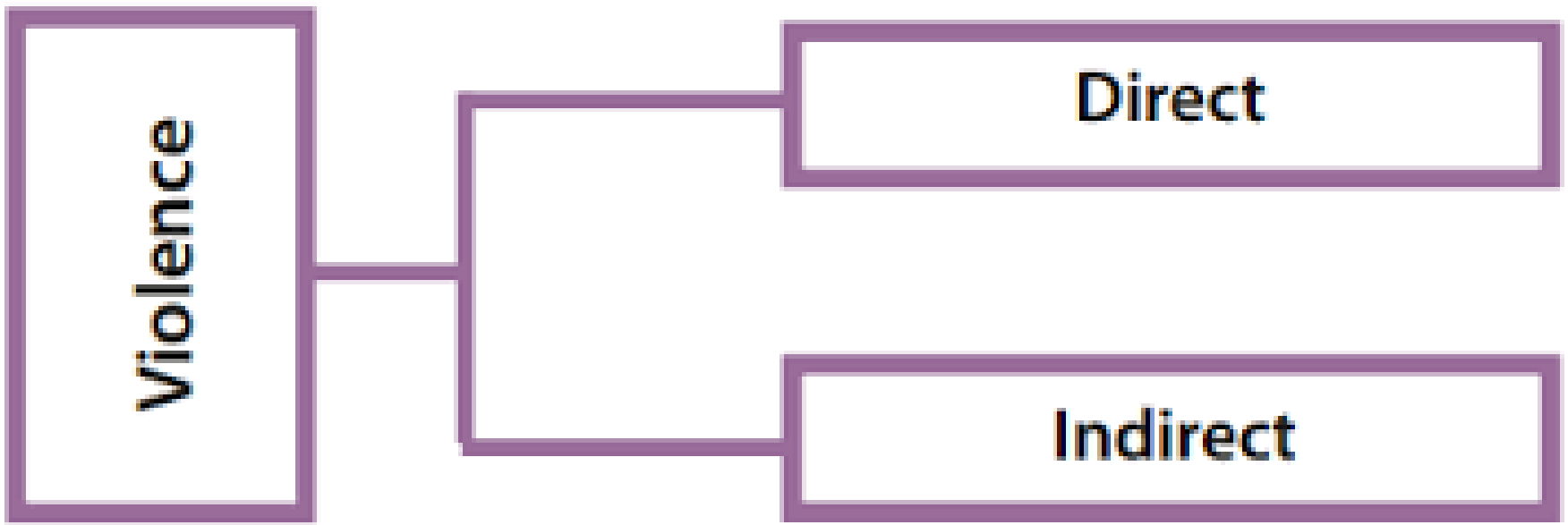
Fastidio = irritabilità

Annoyance is an unpleasant mental state that is characterized by such effects as irritation and distraction from one's conscious thinking. It can lead to emotions such as frustration and anger. The property of being easily annoyed is called irritability.

Classificazione empirica

Specifici aspetti di comportamenti infantile, potenzialmente problematici, in base alla frequenza con cui si presentano vengono raggruppati in due pattern:




Violence
Direct
Indirect

Indirect Aggression

Indirect Aggression allows the perpetrator to avoid confronting the target directly, making it seem as though there is no intent to harm.

La donna è più irascibile dell’uomo?


CREDO CHE MOLTI DEI TUOI PROBLEMI, LUCY, SI RISOLVEREBBERO SE AVESSI UNA COPERTA...
FORSE SE AVESSI UNA COPERTA NON SARESTI COSI' SCORBUTICA E COSI'...
POW!
...FACILMENTE IRASCIBILE!
Schulz

Gender and Aggression

- Universal findings that men are more violent than women.
  - Differences stable over time and place.
- Challenges to the notion that men are more aggressive than females.
  - Boys tend to be more overtly aggressive.
  - Girls often are more indirectly, or relationally, aggressive.

Review of General Psychology
2004, Vol. 8, No. 4, 291–322

1089-2680/04/$12.00 DOI: 10.1037/1089-2680.8.4.291

Sex Differences in Aggression in Real-World Settings: A Meta-Analytic Review

John Archer
University of Central Lancashire

The sex difference in physical aggression showed an early onset, which is consistent with the position of evolutionary developmental psychologists.

There was no sign of a cumulative increase during the childhood years, as expected from the gradual impact of gendered social learning.

The sex difference did not increase at puberty, suggesting no discernible influence of testosterone, but it did increase from 18 to 30 years, the peak of reproductive activity; this is consistent with Social Selection Theory's emphasis on greater intermale competition during that age period.

Indirect aggression showed an increase between 6 and 17 years, consistent with its importance for girls during the early teenage years.

Sex Differences in Overall (Direct), Physical, Verbal, and Indirect Aggression, Along With Anger, From Self-Reports, Observations, Peer-Reports, and Teacher Reports

Type and method	*d*	CI	*k*	Q_w	$P(Q_w)$
Overall					
Self-report	.42	0.39, 0.45	75	490.5	<.0001
Outliers removed	.30	0.27, 0.34	54	75.0	.05
Observation	.49	0.40, 0.58	27	30.0	.54
Peer report	.57	0.53, 0.60	36	180.5	<.0001
Outliers removed	.63	0.58, 0.67	28	41.3	.07
Teacher report	.42	0.37, 0.46	31	68.6	.0001
Outliers removed	.47	0.42, 0.51	28	37.0	.19
Physical					
Self-report	.39	0.38, 0.41	111	1,179.7	<.0001
Outliers removed	.59	0.56, 0.62	63	85.3	.06
Observation	.53	0.43, 0.62	43	68.4	.01
Outliers removed	.55	0.45, 0.64	42	55.8	.12
Peer report	.84	0.80, 0.89	21	174.8	<.0001
Outliers removed	.80	0.74, 0.86	14	20.3	.09
Teacher report	.40	0.36, 0.45	11	70.1	<.0001
Outliers removed	.33	0.27, 0.39	7	7.8	.25
Verbal					
Self report	.30	0.27, 0.33	68	248.9	<.0001
Outliers removed	.19	0.16, 0.23	56	73.8	.09
Observation	.14	0.02, 0.26	29	53.1	.004
Outliers removed	.09	−0.04, 0.21	27	40.4	.06
Peer report	.51	0.45, 0.56	14	30.4	.004
Outliers removed	.55	0.48, 0.61	13	20.9	.05
Teacher report	.24	0.13, 0.34	3	1.4	.49
Indirect					
Self-reports combined	−.02	−0.07, 0.02	40	145.9	<.0001
BDHI scale	−.16	−0.23, −0.09	18	44.1	<.001
Other methods	.05	−0.004, 0.10	22	81.8	<.0001
Observation	−.74	−0.94, 0.54	4	10.5	.01
Outliers removed	−.45	−0.72, −0.18	3	0.4	.81
Peer reports combined	−.10	−0.14, −0.06	26	164.4	<.0001
Peer rating	−.19	−0.25, −0.13	14	105.1	<.0001
Peer nominations	−.01	−0.07, 0.04	12	40.7	<.001
Teacher report	−.13	−0.24, −0.03	8	18.5	.01
Outliers removed	−.21	−0.33, −0.09	7	10.5	.10
Anger					
Self-report	−.003	−0.03, 0.02	46	104.9	<.0001
Outliers removed	−.035	−0.06, −0.01	43	60.1	.06

Note. Effect sizes are positive if in the male direction and negative if in the female direction. *d* = mean effect size weighted by sample size; CI = confidence interval; *k* = number of samples; Q_w = homogeneity of effect sizes; BDHI = Buss-Durkee Hostility Inventory.

Gender-Inclusive and Gender-Informed Treatment of Anger

EPHREM FERNANDEZ AND KATHLEEN MALLEY-MORRISON ■

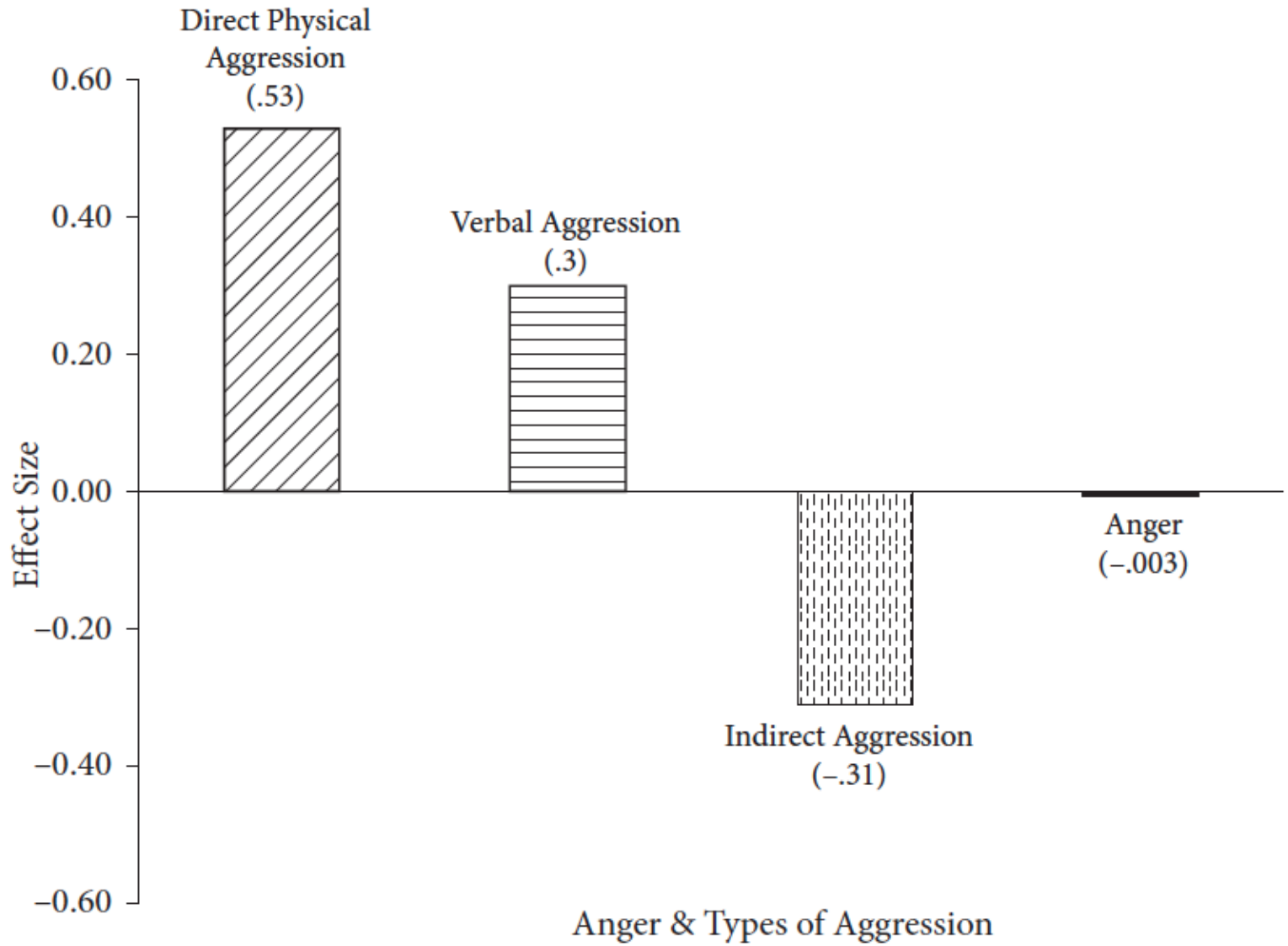


Figure 12.2 Gender-difference effect sizes for anger and types of aggression. Positive effect size indicates males > females; negative effect size indicates females > males. Based on meta-analysis by Archer (2004).

SINTESI

- Uomini e donne differiscono per tipo di aggressività (tratto) e irascibilità impulsiva (stato)
- Aggressività e irascibilità possono raggiungere picchi in diverse età della vita
- Non vi sono elementi che testimonino un aumento di irascibilità nel periodo pre- o postmenopausale nella donna

La dimensione dell’**IRRITABILITA’**

Arch Womens Ment Health (1999) 2: 153–167

Archives of Women's Mental Health

Review article

Irritability: the forgotten dimension of female-specific mood disorders

L. Born and **M. Steiner**

Irritability, and not depression or anxiety, is frequently the primary presenting complaint in women with premenstrual, perinatal, and perimenopausal mood disturbances. Both the historical writings and contemporary research – in particular research on female-specific mood disorders, suggest congruence with the notion of severe irritability as a distinct mood condition. This overview represents not an introduction but rather a resurrection of a longstanding and familiar, yet elusive phenomenon.

MENOPAUSA

Neuropsychology Review, Vol. 13, No. 3, September 2003 (© 2003)

A Review of Symptoms Commonly Associated with Menopause: Implications for Clinical Neuropsychologists and Other Health Care Providers[1]

Sid E. O'Bryant,[2] Anjali Palav,[3] and Robert J. McCaffrey[2,4]

Table I. Base Rates of Menopausal Symptoms in Premenopause

Symptom	Premenopause N^a	Base rate (%)
Abdominal discomfort	53/376[b,c]	14
Aches and pains in muscles or joints	1060/4123[b,c,e,f,h]	26
Aches in neck and skull	85/300[h]	28
Anxiety	577/2508[b,f]	23
Backaches	130/376[b,c]	35
Bladder control problems	378/3179[b,c,f,g]	12
Breast symptoms	299/2508[b,f]	12
Concentration difficulties	63/316[c]	20
Depression	818/3124[b,c,f,h]	26
Dizziness	660/3124[b,c,f,h]	21
Fatigue, tiredness, lack of energy	890/1675[b,c,e,h]	53
Headache	1141/4123[b,c,e,f,h]	28
Hot flushes/flashes	798/4123[b,c,d,f]	21
Irritability	868/3447[e,f]	25
Nervousness	136/376[b,c]	32
Paresthesias	67/376[b,c]	18
Rapid or pounding heart	271/2824[b,c,f]	10
Shortness of breath	57/376[b,c]	15
Sleep disturbances	732/3124[b,c,f,h]	23
Sweating	579/3704[c,d,f,h]	16
Vaginal symptoms	370/3443[d,f,g]	11
Weight gain	129/300[h]	43
Worry about body	90/300[h]	30

[a]The number of women who experienced that symptom over the total number of women interviewed about the symptom.

Table II. Base Rates of Menopausal Symptoms in Menopause

Symptom	Menopause N^a	Base rate (%)
Abdominal discomfort	60/549[b]	11
Aches and pains in muscles or joints	3135/7250[b,c,d,e,h]	43
Aches in neck and skull	8/40[h]	20
Anxiety	128/494[d]	26
Backaches	209/549[b]	38
Bladder control problems	576/6406[b,d,e]	9
Breast symptoms	74/494[e]	15
Concentration difficulties	154/549[b]	28
Depression	1492/7078[b,d,e,f,h,i,j]	21
Decreased interest in sex	108/457[i,j]	24
Dizziness	837/6535[b,d,e,f,h]	13
Fatigue, tiredness, lack of energy	2496/7234[b,c,d,h,j]	35
Headache	2241/7339[b,c,d,e,f,h]	31
Hot flushes/flashes	2373/7917[c,d,e,f,h,I,j]	30
Irritability	1755/7226[c,d,e,f,j]	24
Nervousness	267/699[b,f,g]	38
Paresthesias	765/5912[b,e]	13
Rapid or pounding heart	817/6406[b,d,e]	13
Shortness of breath	700/5912[b,d]	12
Sleep disturbances	2076/7730[b,c,d,e,h,j]	27
Sweating	2375/7984[b,c,d,e,f,h,i,j]	30
Vaginal symptoms	434/5857[d,e]	7
Weight gain	294/609[f,h,j]	48
Worry about body	10/40[h]	25

Table III. Base Rates of Menopausal Symptoms in Postmenopause

Symptom	Postmenopause N^a	Base rate (%)
Abdominal discomfort	64/415[b,c]	15
Aches and pains in muscles or joints	677/1942[b,c,d,f,j,k]	35
Aches in neck and skull	63/129[j,k]	49
Anxiety	327/1335[b,e]	24
Backaches	154/415[b,c]	37
Bladder control problems	523/2781[b,c,f,g,h]	19
Breast symptoms	286/1710[b,b,f,h]	16
Concentration difficulties	123/588[c,h]	21
Depression	500/2052[b,c,f,h,k]	24
Dizziness	598/1750[b,c,f,k]	33
Fatigue, tiredness, lack of energy	773/1628[b,c,d,k]	47
Headache	318/2002[b,c,d,f,k]	16
Hot flushes/flashes	741/2052[b,c,f,h,j,k]	36
Irritability	491/1760[e,f,h]	28
Nervousness	193/484[b,c,j]	40
Paresthesias	282/790[b,c,d,i]	36
Rapid or pounding heart	305/1923[b,c,f,h]	16
Shortness of breath	70/415[b,c]	17
Sleep disturbances	1223/3205[b,c,d,f,j,k]	38
Sweating	854/3076[c,d,e,f,k]	28
Vaginal symptoms	409/2366[f,g,h]	18
Weight gain	23/60[k]	38
Worry about body	51/129[j,k]	40

Psychother Psychosom 2009;78:128–130
DOI: 10.1159/000203120

Irritability in Menopause: An Investigation of Its Relation to Menopausal, Hormonal and Physical Factors

A.C. Spyropoulou[a], I.M. Zervas[a], G. Christodoulakos[b], I. Lambrinoudaki[b], D. Rizos[c], K. Koundi[a], E. Sanida[a], G. Creatsas[b], C.R. Soldatos[a]

163 peri- and postmenopausal women

Outward and inward irritability of peri- and postmenopausal women was found to be related to chronic disease, a factor that is not specific to menopause but may be partially influenced by the older age of menopausal women.

The 'domino theory' suggesting that vasomotor and sleep problems may function as mediators in forming an association between menopause and mood symptoms was not established.

Outwardly directed irritability was found to be related to FSH and LH levels. There are no data supporting a possible direct association between FSH and LH and the expression of outward irritability. However, as FSH and LH are markers of ovarian aging and menopause, our results may give an indication of a link between outward irritability and menopause.

Table 1. Regression coefficients ± standard error of study variables on inward and outward irritability from the multivariable model

	Inward irritability β ± SE	Outward irritability β ± SE
Age, years	−0.02 ± 0.05	−0.03 ± 0.07
Employment status		
Employed (ref.)		
Housewife/unemployed	0.14 ± 0.60	0.03 ± 0.79
Retired	−0.80 ± 0.69	−1.10 ± 0.89
Family status		
Married (ref.)		
Other	0.58 ± 0.059	−0.28 ± 0.78
Children		
None (ref.)		
1–2	−0.53 ± 0.78	0.65 ± 0.98
>2	−1.37 ± 0.97	−0.72 ± 1.34
Menopausal status		
Perimenopausal (ref.)		
Postmenopausal	−0.19 ± 0.72	−0.79 ± 0.96
Chronic disease		
No (ref.)		
Yes	1.07 ± 0.53[a]	1.08 ± 0.54[a]
FSH, μIU/ml	–	0.03 ± 0.01[a]
LH, μIU/ml	–	0.05 ± 0.02[a, b]

[a] $p < 0.05$.
[b] Regression coefficient derived from a new model adjusted for all other variables.

Arch Womens Ment Health (2014) 17:279–289
DOI 10.1007/s00737-014-0434-7

ORIGINAL ARTICLE

Depressive symptoms in the transition to menopause: the roles of irritability, personality vulnerability, and self-regulation

Viviana Mauas · Daniel C. Kopala-Sibley · David C. Zuroff

376 women

Higher levels of irritability were associated with poorer emotional regulation in highly self-critical women, but not in less self-critical women, and poorer emotional regulation was, in turn, related to higher levels depressive symptoms.

Findings suggest that the transition to menopause may represent an especially vulnerable period for women with high levels of self-criticism.

Although irritability is transitory for most women, for women who are highly self-critical, irritability may tax their ability to self-regulate and lead to more encompassing symptoms of depression.

Table 1 Combined sample: summary of intercorrelations, means, standard deviations, and

Variable	1	2	3			
(1) Depressive symptoms	–					
(2) Irritability	0.55***	–				
(3) Self-criticism	0.56***	0.48***	–			
(4) Somatic symptoms	0.38***	0.42***	0.19**	–		
(5) DSR	0.47***	0.48***	0.52***	0.08	–	
(6) ATMA	−0.47***	−0.42***	−0.33***	−0.13**	−0.35***	–
M	8.86	6.83	109.54	3.36	34.48	16.14
SD	6.76	6.06	19.59	2.67	10.39	3.11
α Value	0.87	0.96	0.8	0.68	0.91	0.7

DSR difficulties in self-regulation, ATMA attitudes toward menopause and ageing

$p<0.10$, $^{*}p<0.05$, $^{**}p<0.01$, $^{***}p<0.001$

Trattamento della irritabilità

Progress in Neurobiology 113 (2014) 79–87

Contents lists available at ScienceDirect

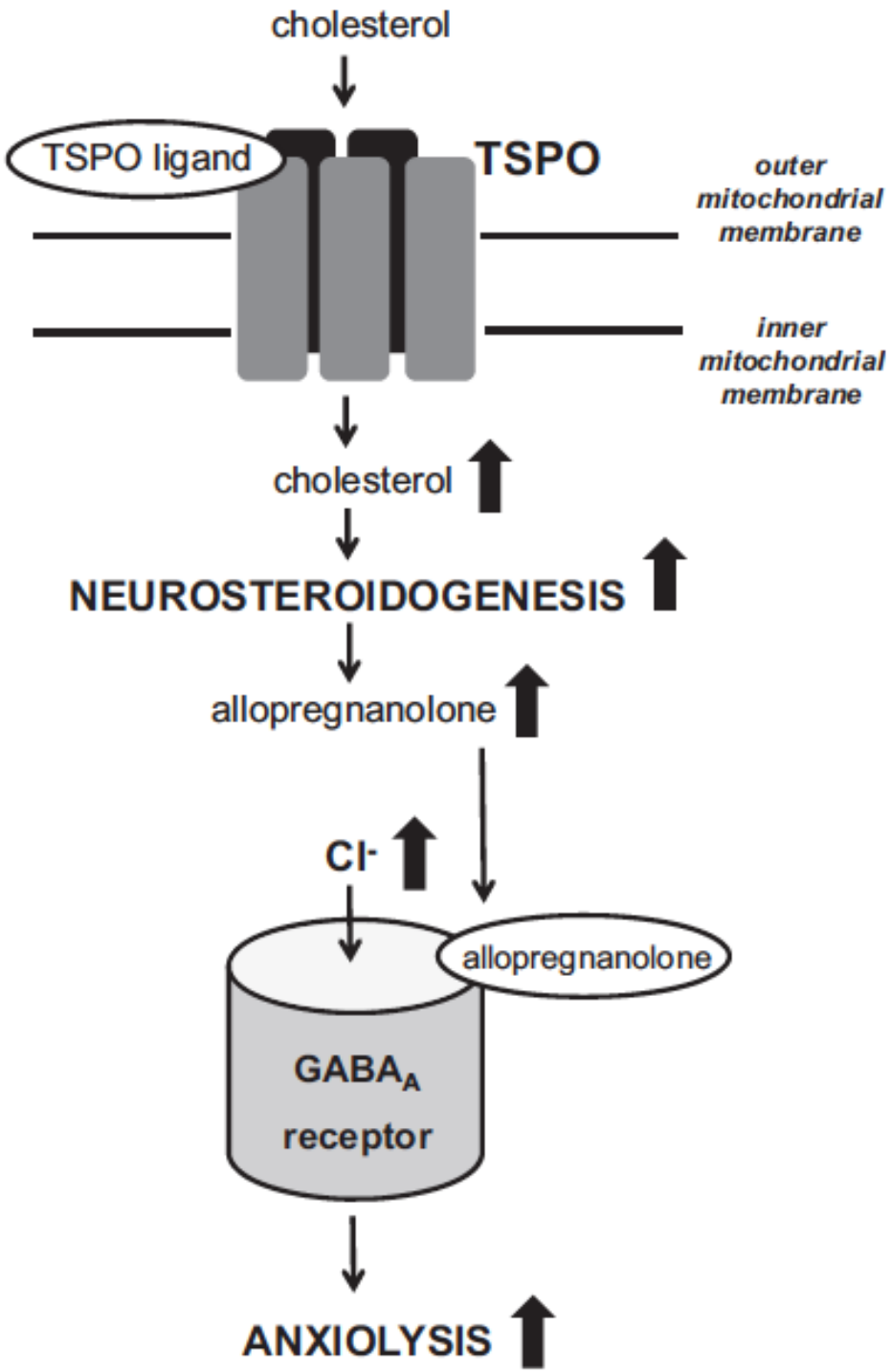
Progress in Neurobiology

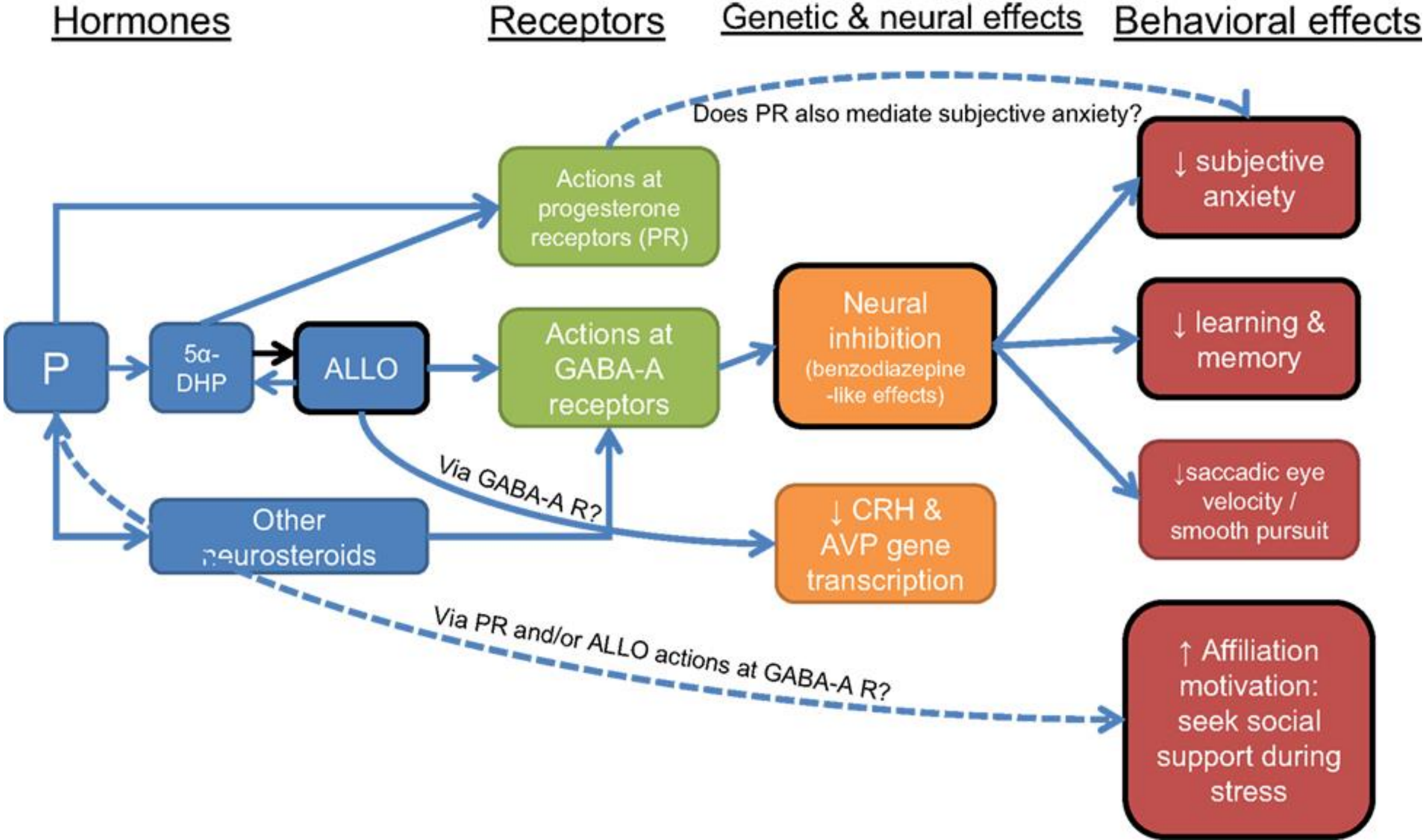
journal homepage: www.elsevier.com/locate/pneurobio

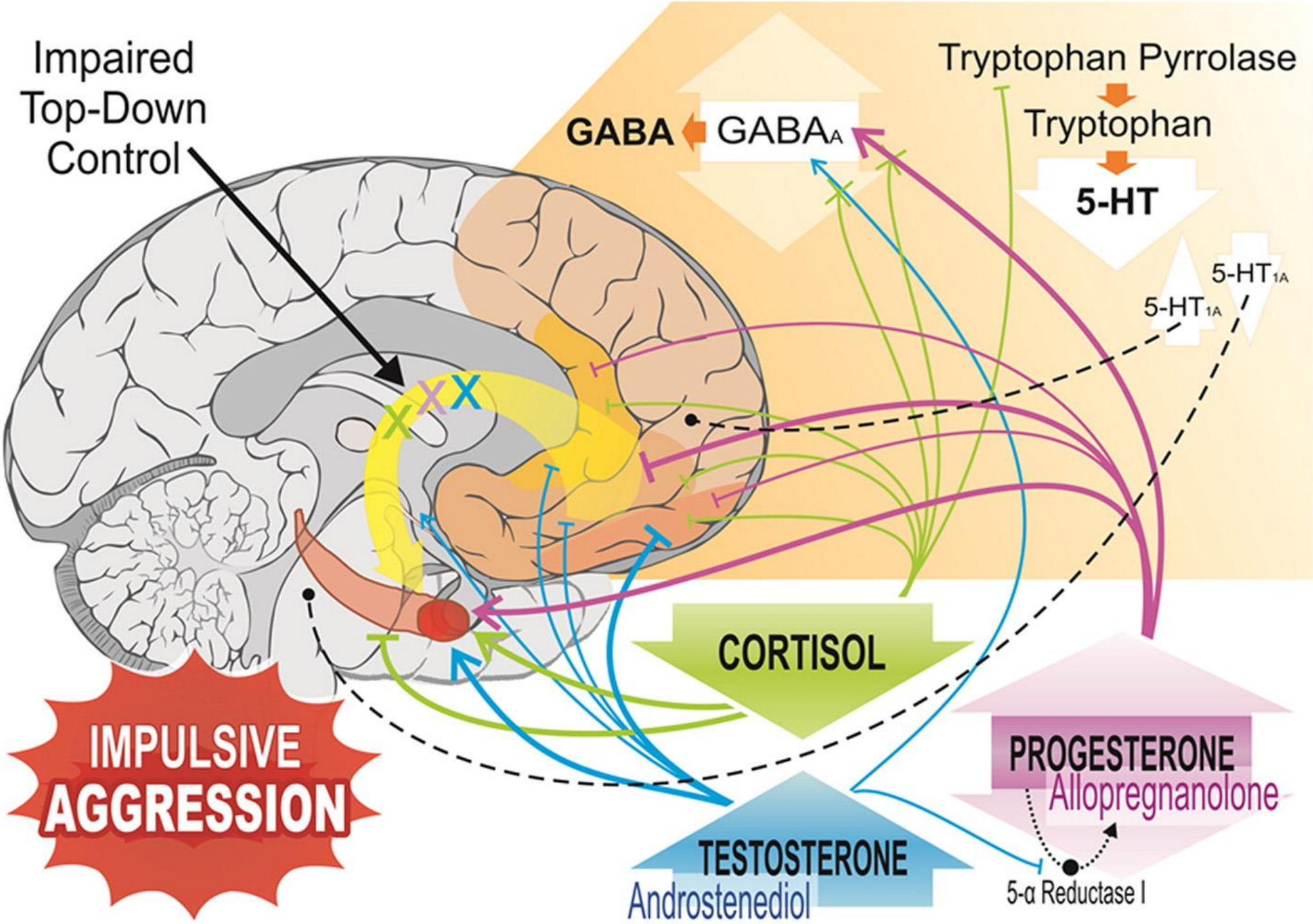
The role of allopregnanolone in depression and anxiety

Cornelius Schüle [a,*], Caroline Nothdurfter [b], Rainer Rupprecht [b]

Progesterone's Effects on GABA		
Progesterone	Allopregnanolone	GABA Receptor Activity
	↑	↑




Hormones
Receptors
Genetic & neural effects
Behavioral effects
Does PR also mediate subjective anxiety?
Actions at progesterone receptors (PR)
↓ subjective anxiety
P
5α-DHP
ALLO
Actions at GABA-A receptors
Neural inhibition (benzodiazepine -like effects)
↓ learning & memory
↓saccadic eye velocity / smooth pursuit
Via GABA-A R?
Other neurosteroids
↓ CRH & AVP gene transcription
Via PR and/or ALLO actions at GABA-A R?
↑ Affiliation motivation: seek social support during stress


Impaired
Top-Down
Control
Tryptophan Pyrrolase
Tryptophan
5-HT
GABA
GABAA
5-HT1A
5-HT1A
CORTISOL
PROGESTERONE
Allopregnanolone
TESTOSTERONE
Androstenediol
5-α Reductase I
IMPULSIVE
AGGRESSION

BJOG An International Journal of Obstetrics and Gynaecology

BJOG Debate

BJOG DEBATE

HRT should be considered as first line therapy for perimenopausal depression

FOR: Estrogens are the first line treatment for perimenopausal women

BJOG PERSPECTIVES

JOHN STUDD, PROFESSOR OF GYNAECOLOGY, LONDON PMS AND MENOPAUSE CENTRE, LONDON, UK

Perimenopausal women with depression (PMD) suffer the many symptoms of the menopausal transition before the cessation of periods, together with anxiety, poor concentration and loss of libido. These women often have a continuum of depression from an early age with a history of hormone-related depression of premenstrual depression (PMS) and a history of postnatal depression (PND). The PND then becomes cyclical with the return of periods, becoming worse with age until the mid-forties. These women are then denied hormone therapy because they are not post-menopausal. This pattern of depression in women is best called reproductive depression (RD) and cannot be diagnosed or excluded by blood tests because the hormone levels will usually be in the pre-menopausal range (Studd & Nappi. Gynecol Endocrinol 2012;28:42–5).

Transdermal estrogens are safer than oral estrogens in that they do not carry any extra risk of thrombosis and also have been reported as more effective in the treatment of depression. This should be by patches or gels giving a reasonably high dose using estrogen patches of 100 mcg twice weekly (Soares et al. Arch Gen Psychiatry 2001;58:529–34). A similar dose of gels should be used. There is often a loss of libido and loss of energy at the same time and these women will benefit from transdermal testosterone. Although it is unlicensed in women, it can be achieved by testosterone gel, Testim or Testogel using approximately one-tenth of the licensed male dose (Studd. Climacteric 2011;14:637–42). Those women with a uterus have to have cyclical progestogen but as these women are progesterone-intolerant it is justifiable to use a shortened course of Norethisterone, Provera or Utrogestan for 7–10 days each month.

Not all women will have the depression removed by hormone therapy and there will be a case for the use of antidepressants in a few women, but I believe this is second line treatment for these patients who do not respond to the more logical transdermal estrogens. I have tried to arrange a lecture for years at the RCPsych but I am informed that there is no interest in this treatment among senior psychiatrists. Is it a territorial issue? Possibly. Is it a safety objection? This is unlikely as transdermal estradiol is safer than long-term antidepressants (Smoller et al. Arch Int Med 2009;169:2128–39). Essentially, the problem is the failure to recognise the hormonal component of perimenopausal depression. This failure leads to an interesting catalogue of explanations: treatment resistant depression (wrong treatment); borderline personality disorder (a familiar DSM V diagnosis); bipolar disorder (it is cyclical after all!); premorbid history of depression (depression also occurred before the current PMD; it was PMS or PND—usually both). Most psychiatrists are not effective when treating depression in women. I hope Michael Craig will be able to instruct them. I have failed.

Disclosures of interests

None declared. Completed disclosure of interests form available to view online as supporting information. ■

AGAINST: More clinical trials are needed

MICHAEL C CRAIG, SENIOR LECTURER & HONORARY CONSULTANT, DEPARTMENT OF FORENSIC AND NEURODEVELOPMENTAL SCIENCES, INSTITUTE OF PSYCHIATRY, LONDON, UK

Observational community studies have reported that during the perimenopause the incidence of depression increases by up to three-fold. This probably includes a significant subgroup of women who are particularly sensitive to fluctuations and/or decline in sex hormones.

It has been argued that this sensitivity constitutes a discreet nosological entity, sometimes referred to as reproductive depression. This is supported by a number of approaches. These include family and twin studies, which reported high heritability of conditions such as premenstrual dysphoric disorder (PMDD), and postnatal depression (PND). Also, studies that iatrogenically induce estrogen withdrawal have found a specific recurrence of depressive symptoms in women with a history of PMDD, PND and/or perimenopausal depression (PMD), but not in control women. Recently, for example, blinded HRT withdrawal was reported to trigger depressive symptoms in postmenopausal women with past PMD responsive to HRT, but not in postmenopausal women without a history of PMD (Schmidt et al. JAMA Psychiatry 2015;72:714–26).

The biological basis of this vulnerability remains unclear. However, it probably includes indirect effects of menopausal symptoms on mood, and a more direct interaction between sex hormones and neurotransmitter systems implicated in depression (Craig. In: Managing the Menopause—21st Century Solutions. Cambridge: Cambridge University Press; 2015: p. 91–102). An important question that follows is whether HRT can be used to treat depression in this subgroup.

In postmenopausal women who are not clinically depressed, some studies have reported that HRT is associated with improvement in psychological 'well-being' (see Craig. Br J Psychiatry 2013;202:9–13). However, other studies have failed to support these findings. In the WISDOM study, for example, 3721 postmenopausal women, aged 50–69, were randomised to HRT or placebo. No significant differences in depression, or overall quality of life, were observed at 1 year. Several studies have also failed to demonstrate superiority of HRT over placebo in clinically depressed menopausal women. However, two RCTs lend greater support to the use of estrogen therapy in perimenopausal women.

The first was a 'pilot study' of 16 women randomised to 17-β estradiol patches (50 mcg) and 18 women prescribed placebo patches (Schmidt et al. Am J Obstet Gynecol 2000;183:414–20). A full or partial therapeutic response was seen in 80% of subjects receiving estradiol and 22% of those receiving placebo ($P < 0.01$). In the second study, 25 women with depressive disorders were randomised to 17-β estradiol skin patches (100 mcg) and 25 women were prescribed placebo patches (Soares et al. Arch Gen Psychiatry 2001;58:529–34). Remission of depression was observed in 17 (68%) women treated with 17-β estradiol compared with five (20%) in the placebo group ($P = 0.001$). Further, the clinical improvement remained significant after the 4-week wash-out period. However, it remains unclear whether improvements extend beyond this time.

In summary, there is preliminary support for the use of estrogen therapy to treat perimenopausal depression. However, larger clinical trials, with longer follow up, and the inclusion/exclusion of other sex hormones are still required before recommending (or advising against) the use of HRT as a first-line medication in perimenopausal depression.

Disclosure of interests

Full disclosure of interests available to view online as supporting information.

Dr Michael Craig is the clinical lead of the National Female Hormone Clinic, Maudsley Hospital, London. This is part of the NHS National Services Directory that accepts NHS and private referrals for the assessment and treatment of women with mental health problems at times of hormonal fluctuation. ■

Curr Psychiatry Rep (2014) 16:517
DOI 10.1007/s11920-014-0517-1

WOMEN'S MENTAL HEALTH (D RUBINOW, SECTION EDITOR)

Hormone Replacement Therapy in the Treatment of Perimenopausal Depression

Jennifer L. Gordon · Susan S. Girdler

Menopausal status: The existing literature, while limited by small sample sizes, suggests that HRT may not be an effective treatment for depression in an older postmenopausal woman.

Timing of depressive symptom onset: Depressive symptoms whose onset coincides with the onset of menstrual irregularity may be more likely to be hormonally related and thusmore responsive to E2 therapy.

History of reproductive mood disorders: A positive history of reproductive mood disorders such as premenstrual dysphoric disorder or postpartum depression may indicate an increased sensitivity to fluctuations in ovarian hormones.

Medical history: E2 therapy has been shown to increase the reoccurrence of venous thromboembolism, endometrial cancer, and breast cancer in women with a positive history of these diseases.

Patient preference: Perhaps more so than any physical disorder, patient buy-in is critical in the treatment of depression. Thus, the treatment modality—HRT, an SSRI, or psychotherapy—should always be chosen with the patient's preference inmind.

Other menopausal symptoms: A trial of HRT as monotherapy may be particularly worthwhile in the case of a woman suffering from severe hot flashes and sleepdisturbing night sweats in addition to D-MT. If depressive symptoms do not remit with HRT, a conventional antidepressant may be prescribed.

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Research Article

EFFICACY OF ESTRADIOL IN PERIMENOPAUSAL DEPRESSION: SO MUCH PROMISE AND SO FEW ANSWERS

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Results

Of the 24 studies meeting criteria for review, only five RCTs examined depressed subjects, and only two of the study samples were solely perimenopausal.

Conclusions

One can generalize from the studies reviewed here only with great caution, but there is little evidence to support the use of estradiol to improve mood in nondepressed patients (not surprisingly) and some evidence to support the antidepressant efficacy of estradiol in perimenopausal but not postmenopausal women.

CONCLUSIONI

- L’irascibilità è un comportamento esternalizzato (overt) collegato alla aggressività
- La donna in generale manifesta l’aggressività in modo indiretto, al contrario dell’uomo
- Aggressività e irascibilità possono avere picchi in diverse età della vita
- Non vi sono elementi che testimoniano un aumento di irascibilità della donna in menopausa
- L’irritabilità è al contrario presente in diverse fasi della vita della donna, inclusa la menopausa
- Particolarmente vulnerabili sono le donne con alti livelli di autocritica e con malattie croniche
- Sono potenzialmente implicati i livelli ormonali di allopregnanolone, che agisce sui recettori GABA
- La HRT è in discussione, ma è soprattutto diretta alla depressione piuttosto che alla irritabilità