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ETHOLOGICAL CHARACTERISTICS OF THE PRIMARY DEPRESSIVE EPISODE

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Abstract

Significant polymorphism of the clinical picture of depression and certain contradictions of scientific views on the nosological specificity of these conditions complicate the establishment of specific clinical and psychopathological signs of endogenous and psychogenic depression, their typology, dynamics, prognosis, which makes the study of nonverbal behavior relevant and promising task. **The purpose** of the study was to establish the psychopathological and clinical-ethological manifestations of the primary depressive episode and to conduct a comparative analysis of endogenous and psychogenic variants of the primary depressive episode. **Contingents and methods**. Based on the principles of bioethics, 96 patients (49 men and 47 women) with primary depressive episode – main group – who applied for outpatient psychiatric department of Zaporizhzhia regional psychiatry clinic in 2018-2021 were clinically examined. Diagnostic conclusions were made in accordance with the ICD-10 criteria. The control group consisted of 35 mentally healthy individuals, comparable in age and gender composition with the study group. **Results.** Patients with mild and moderate severity of the primary depressive episode are characterized by sad look, poses

of reflection, submission, concentration in combination with facial expressions of suffering, guilt, helplessness, pensiveness, sideways, wrinkles on the forehead, stereotyped hand movements, head, head, reducing the synchronicity of gestural, facial and motor components of motility; avoidance of contacts and a sharp decrease in reactions to external influences. Severe manifestations of depression are characterized by sad and mournful facial expressions, lowered corners of the mouth, quiet voice, motor retardation, facial expressions of suffering, guilt and shame. **Conclusion.** The ethological component of the clinical-psychopathological method, based on the description of nonverbal behavior, can significantly improve the diagnostic capabilities of early detection of depressive episode, provides additional tools for typological differentiation and severity of patients with primary depressive episode.

Key words: depression clinical picture; primary depressive episode; nonverbal behavior.

Introduction. The problem of depression, as one of the most common mental disorders, is in the spotlight of domestic and foreign researchers. According to the WHO, more than 100 million people in the world show signs of depression and, accordingly, need adequate medical care, the quality of which depends on proper diagnosis [1]. Clinical and psychopathological method consists of phenomenological and clinical description of the typology of psychopathological symptoms, syndromes, syndromogenesis [2], nosological forms, while the study of nonverbal behavior (NB) is not subject to detailed analysis and quantification [3-6]. It is necessary to agree with the authors of the clinical-ethological method [3–5], Korobov A. A., Samokhvalov V. P., that it is necessary to investigate in more detail the possibilities of accounting for NB for diagnosis, differential diagnosis, course and prognosis of mental illness, including depression.

The most common scales for assessing depression and anxiety A. Hamilton (1967), A. Montgemery, M. A. Asberg (1979) and others [7, 8], do not contain in their structure assessment of nonverbal behavior. However, the Scales of Behavioral Differential Diagnosis of Depression based on patient NB were proposed by J. Pedersen (1988), proved their effectiveness, and even in some respects prevailed in the informativeness of the scale for assessing depression and anxiety A. Hamilton [9]. It should also be noted that the possibilities of accounting for emergencies in depressive states are used very limited. Significant polymorphism of the clinical picture of depression and certain contradictions of scientific views on the nosological specificity of these conditions complicate the establishment of specific clinical and psychopathological signs of endogenous and psychogenic depression,

their typology, dynamics, prognosis, which makes the study of NB, relevant and promising task.

The purpose of the study: to establish the psychopathological and clinical-ethological manifestations of the primary depressive episode and to conduct a comparative analysis of endogenous and psychogenic variants of the primary depressive episode.

Contingents and methods

Based on the principles of bioethics, 96 patients (49 men and 47 women) with primary depressive episode – main group (MG) – who applied for outpatient psychiatric department of Zaporizhzhia reginal psychiatry clinic in 2018-2021 were clinically examined on the basis of informed consent. Thetime of onset of symptoms was 21.3 ± 4.6 years. The duration of the disease in patients ranged from one to three months (average 1.9±1.1 months). Diagnostic conclusions were made in accordance with the ICD-10 criteria. The control group (CG) consisted of 35 mentally healthy individuals, comparable in age and gender composition with the study group.

At the time of the examination, the patients did not receive drug therapy, had no signs of psychotic disorders and signs of organic damage od central nervous system. All subjects were tested to determine the level of depressive disorder, according to the unified clinical protocol of highly specialized medical care approved by the Ministry of Health of Ukraine from December 25, 2014 № 1003, according to the Hamilton Depression Rating Scale (HDRS), and the Clinical Global Impressions Scale (CGI-S).

The description of the NB consisted of three stages using the following methods: at the first stage, at the time of the initial treatment of patients for medical care, a general description in the framework of clinical and psychopathological research; at the second stage the study of clinical and ethological characteristics of patients in interaction with a doctor in an outpatient setting with the selection of elementary units of NB through facial expressions, posture, gestures, simple and complex behaviors, based on a glossary on human NB (Samokhvalov V.P., 1987, 1994; Korobov A.A., 1991). At the last, third stage, recoding of NB into ethological elements according to AA Korobov's glossary (1991) was carried out. Subsequently, after completion of the clinical diagnosis procedure according to ICD-10 and completion of follow-up, patients were divided into groups of endogenous G1 (n = 52) and psychogenic G2 (n = 44) origin, and the results were processed. Statistical analysis was performed using the licensed application package Statistica 10.

Results and discussion

All patients belonged to Caucasian, Ukrainian (77.1%) and Russian (22.9%) nationalities; by religious affiliation to Orthodoxy. In cases where the respondents indicated that they were atheists, they chose Orthodoxy as a historical religion. According to social status and profession, patients were distributed as follows: employees – 51, workers – 28, students – 4, temporarily unemployed – 13. In 35.36% of MG picnic constitution, asthenic – 37.46%, normosthenic – in 27, 81%.

Analysis of simple forms of individual behavior allowed to obtain the following results: individual distance – was determined when the patient entered the office and approached the doctor, then offered to take a chair and sit down to talk to the doctor and monitor changes in distance. In the standing position at the entrance to the office, the individual distance was about 170 cm for mentally healthy men, 200 cm for women; in patients with depression, men – 250 cm, women – up to 300 cm. The proposed chair (installed at a distance of 350 cm) did not move and sat 49 patients (51.1%). The rest (48.95%) of patients moved their chairs to the doctor's table. 34 patients (35.42%) reduced the individual distance to 200 cm. A distance of up to 150 cm was occupied by 14 men and 16 women. Individual distance up to 100 cm was reduced by 20 men and 18 women Individual distance was reduced during the conversation of 32 patients (18 men and 14 women) (33.3%). It should be noted that patients with symptoms of asthenia did not change the distance.

Analysis of the orientation of the body in space, during the contact of the MG, showed that with the direct orientation of the body in relation to the interlocutor was found in 83.30% MG and 74.23% CGlateral orientation in 15.63% MG and 22.86%, CG moreover, in women it occurred in almost a third of cases more often than in healthy and sick patients in 29.79% of MG and 47.06% of CG; other variants of body position were not encountered.

Despite the generally accepted opinion about mainly facial expressions of suffering and pain, as well as severe hypomimia in patients, especially endogenous depression, there were also manifestations of a smile. But we can hardly consider the demonstration of a smile as a manifestation of the emotional state of joy: they were unique: forced smile (17.7%) – facial expressions "tired", sad, "glued", ie, facial expressions without a corresponding emotional state of joy; smile with a grin (11.45%) – manifested by a grin of teeth, raising the edge of the lips, also forced, without vocalization and other components of the smile; "Curved" smile (6.25%), characterized by asymmetry not only of the mouth but also of the eyebrows and even the eyes; "Violent" (3.12%) – external facial expressions without appropriate emotional support with an understanding of the unnaturalness of such facial

expressions; facial expressions dissociated from the general condition (4.16%) were characterized by a change in the mobility of the mouth, eyebrows, eyes from one side to the other, which outwardly gives the impression of moving facial expressions on the face; sad smile (21.87%) – most characteristic of endogenous depression in some cases with the presence of Veraguth's fold. Among other complexes, the most common were: facial expressions of suffering (71.87%), guilt (41.7%), helplessness (27.08%), hypomimia (21.87%). Less common were facial expressions of crying (7.29%), misunderstanding (13.54%), thoughtfulness (9.37%).

Analysis of eye contact showed that in conversations with patients with endogenous depression (G1) eye contact may be completely absent (in 90.38% of cases against 13.63% in G2) with active avoidance of gaze in response to an attempt to look into the eyes . Most often in both groups there was periodic eye contact G1 – 25% and G2 61.36%, the restoration of which was carried out by the patient after treatment and questions from the doctor depended mainly on the doctor's questions (45.83%). Spontaneous glances were directed downwards, at the hands or floor G1 (5.76%) and G2 (11.36%), window G1 (1.92%) and G2 (11.36%), door G1 (1.92%)) and G2 (9.1%), the body of the interlocutor G1 (1.92%) and G2 (9.1%), views on their own hands (14.2%) source (chandelier, lamp) of light 9.83% in space in front of you (24.6%).

Predominant disorders of facial complexes of the MG contingent in the primary depressive episode are manifested not only in the well-known typical types of facial expressions – suffering, guilt, helplessness, but also in the gradual change in the dynamics of facial expressions and its transitions. An important component is the compliance of facial expressions with its communicative function. Facial reactions in endogenous depression are stereotyped and if the first treatment and the first communicative meetings are often observed slight dynamics (at the beginning of the conversation for 5-10 minutes) facial expressions are more dynamic in relation to further communication) facial expressions, then later they become stereotyped .

Analysis of gestures of patients of both groups showed the characteristic presence of characteristic gestures – accent G1 (7.69%) and G2 (15.9%), address G1 (26.92%) and G2 (34.09%), obedience G1 (5, 76%) and G2 (25%), gestures of thoughtfulness G1 (26.92%) and G2 (25%), elimination of G1 (9.61%) and G2 (15.9%), disgust G1 (3.84%)) and G2 (18.18%), confusion G1 (13.46%) and G2 (20.45%), latent anxiety gesture G1 (1.92%) and G2 (63.63%). Patients did not meet gestures of hug, approval, completed action, gestures of demonstration.

A study of the motility of the head confirmed that the movements of the head are quite pronounced in the GC and are manifested by nods, swaying, throwing and "shaking" (sharp, impulsive movement of the head from right to left or vice versa). In patients with depression there was only a tilt of the head forward or forward and more often to the left (outside the "tired head") G1 (1.92%) and G2 (20.45%), and nods G1 (3.84%) and G2 (15.9%), more complex head movements are not noted. Shoulder and torso motility. One of the most common signs of shoulder motility is a wide spread of the shoulders in the CG (11.42%) and the reduction of the shoulders G1 (30.76%) and G2 (18.2%). Decreased mobility of the shoulders and torso G1 (34.61%) and G2 (13.63%), as well as the reaction of the shoulders were very characteristic.Among the signs of torso motility, along with lateral position, general forward tilt, elimination, there are more complex behavioral complexes – tremors during emotional manifestations of anxiety in the form of contraction of the muscles of the shoulders and upper torso, resembling movements of the torso and shoulders during crying. chills G1 (17.3%) and G2 (2.27%). In patients with G1 there were crying reactions in 17.3%, but without tears, often with elements of tremor. Moreover, tremors were detected under the influence of minor external sound stimuli (phone call, door opening, etc.). In our opinion, such non-verbal-behavioral reactions are a sign of high levels of anxiety and internal tension of patients.

Hand motility (manipulation) with an object, body part or clothing G1 (17.3%) and G2 (38.63%). Patients were more likely to manipulate their own fingers G1 (7.69%) and G2 (36.36%) or clothing G1 (9.61%) and G2 (11.36%). The movements of the fingers in patients were outwardly involuntary and associated with the gesture. This movement of the fingers was most often encountered with one hand – the fingers of one hand moved, rubbed the brush or fingers of the other, that is, were quite monotonous, in contrast to the movements of persons CG. Manipulation of clothes was represented by moving the edges of clothes, belts, buttons, earrings in the ears, rubbing the lips and chin, wiping the lips. These types of manipulation were stereotypical, monotonous. Manipulation of objects in the main group of MG was not observed.

Of the other motility complexes, there were sighs or coughs in G1 (15.38%) and G2 (27.27%), which were accompanied by the sound of "heavy" breathing, combined with gestures of embarrassment, facial expressions of helplessness, suffering, crying. These complexes in the contingent of CG.

In MGpatients established: stereotype of sad facial expressions (18.75%), obedience (23.95%), indifference (18.75%)and suffering (13.54%) in all cases. Also in 21.87%, there

were stereotypes in the form of finger games (picking, rubbing, etc.). Less frequently (15.62%) there were stereotypes in the motility of the shoulders and torso, stereotypes of the head (7.29%), legs (usually raising and lowering the knees, tapping the feet) – 11.45%. In addition to the above, there are stereotypes of orientation 9.6%, taxis and kinesis 7.29%, gesture, eye contact. Stereotypes intensified and became more complicated with additional external stimuli and decreased without external stimuli. The number of stereotypes increased in proportion to the severity of depressive symptoms.

Observation of complex forms of individual behavior allowed us to establish some of their features. The majority of patients of MG (92.7%) had a slow pace.

The desire for comfortable behavior was observed in only 11.45% of patients. It was expressed in attempts to sit more comfortably on a chair, change the position during the conversationand straighten clothes, more comfortable position in relation to the interlocutor.

In patients with endogenous depression, imitation behavior, ie the patient's repetition of actions and movements of the doctor (gestures, facial expressions) was not observed, in contrast to CG (14.28%).

Reactions of eating behavior in CG are manifested by licking, chewing movements, swallowing, touching a finger or object to the lips, movements of the oral region, manipulation of objects on the table. In patients of the main group of these forms of eating behavior is not established. Upon further observation, it was noted that patients (in case of continued treatment in a day hospital) did not ask for food, did not ask relatives to bring something specific from the food. With a severe degree of depression, patients claimed that they did not need food sometimes for 2-3 days and ate more often, "because you need to eat", or selectively refused to eat during the day (breakfast, lunch or dinner) with facial expressions of dissatisfaction, suffering. In psychogenic depression, eating behavior depended on the severity of depression or anxiety. In a mild depressive episode, selective food choices were noted.

The etiquette of greeting and farewell was not always presented. In CG 97.14% in the group of patients 48.95%. Violations of the etiquette of greeting and farewell were especially pronounced in severe manifestations of severe depression. Also, patients with depression did not show signs of dominance and territorial behavior. In contrast to the GC where the "invasion" of "foreign" territory (actions in the office where the inspection was conducted) was rapid in 14.28%, cautious in 25.71%, normal in 60%, clearly showed a decrease in such behavior in depression – without invitations to the office "did not look" 73.95% of patients. In addition, in the group of patients, a decrease in the holistic attitude to the new territory was

determined. Increased interest in the new territory, with a constant inspection of only 11.45%, careful inspection of theft – 46.87%, lack of interest in the new territory 34.37%. Another characteristic (55.2% of patients) sign was not the completion of intentions, in the form of the intention to speak, move, cry, meet the interlocutor, which is often manifested by a state of confusion.

Thus, the study of elements of motor acts, the simplest and most complex forms of behavior shows that primary depressive episode does not have fundamentally new forms of behavior specific to this group of patients, but there are quite characteristic changes, signs of which can be used in clinical and psychopathological diagnosis.

Analysis of NB by the severity of primary depressive episode allowed to identify the following ethological signs (symptoms): in a mild depressive episode are often identified outside of reflection and submission, but no posture of the embryo, prayer or squatting. Often there is a sideways look, a short look at the doctor's face lasting 3-5 seconds. Sad eyebrows, but no wrinkles on the forehead and Veraguth's fold. Characterized by frequent blinking and trembling of the eyelids, sad eyes. There is restlessness of the hands, especially the fingers, as both, and one – squeezing, stroking, intertwining fingers. Usually there is a tilt of the head forward. Elementary complexes of elements of movements of the head, shoulders, torso, legs, individual distance are no different from those of persons CG. In 54.16% of cases, patients did not use nonverbal greetings, replacing them with verbal explanations of the reasons for visiting. Very often from facial expressions instead of hypomimia there is an "ironic" smile – an asymmetrical, sad smile, a "glued" smile, a "crooked" smile. Most often (58.3%) there were facial expressions of suffering and guilt with a strong desire for stereotypes. A mild depressive episode is characterized by periodic avoidance of vision. Among the typology of gestures are gestures of thoughtfulness, elimination, obedience, embarrassment, and sometimes latent anxiety. Many patients have some slowing of the whole complex locomotion system. There is a decrease in interest in new things, cosmetics, makeup, jewelry, hairstyles, faces, although the usual ritual actions are preserved in relation to clothing, appearance. Comfortable behavior in the process of communication is preserved. Behavior of attention and territorial behavior did not differ from the CG. Behavior of intentions is realized as in mentally healthy people.

In a moderate and severe depressive episode, posture, subordination, and reflection were noted. In a sitting position – poses of increased staticity: coachman, reflection, submission, embryo, prayer, concentration. A sideways, downward, or arm examination, a brief glance at the doctor (up to 3 seconds), and a downward or sideways gaze prevailed.

Elongated mouth with trembling corners of the mouth or compressed lips or lowered corners of the mouth with yawning or licking are typical. Very often sad eyebrows with Veraguth's fold with vertical and horizontal wrinkles. Frequent blinking and trembling of the eyelids, squinting eyes, sometimes with bags under the eyes. Eyes dim, sad or indifferent. Most often the hands are fixed on the thighs, less often – on the knees; hands clasped in a lock or move each other's fingers, transfer them to the chest. The torso, shoulders and head are sometimes tilted forward, less often – with a skew. Most often, the knees are raised, there is a slowness of mobility of the legs. Individual distance when communicating in a standing position is much higher (from 0.5 to 1 meter) than in the mentally healthy; at the same time higher at sick women. Patients hardly use non-verbal greetings. Direct orientation towards the doctor prevails. In our observations, peculiar smiles were observed in 11.36% of patients: forced, exhausted, "curve", asymmetric smiles with dissociated inclusion of facial elements. Facial expressions of suffering, guilt, helplessness, misunderstanding, attention and amimic crying were most often observed. Eye contact was absent or extremely short in 23.34% of all patients, often with the avoidance of looking into the eyes of the doctor, and directing it to the mouth, chin, neck of the doctor. Patients more often look at their knees, arms, floor, less often – sideways or on the body of the interlocutor.

The typology of gestures in a moderate depressive episode included gestures of obedience, treatment, contemplation, elimination, embarrassment, gesture of latent anxiety. The motility of the head differed in the desire to predominate the tilt of the head slightly forward or forward and slightly to the side ("tired head"). In the motility of the shoulders and torso, the most common are rare movements of the shoulders and torso, along with a decrease in the reaction of the shoulder, their orientation – rotation, tilt, removal, less often – tremor ("convulsion"), especially with facial expressions crying. The motility of manipulation is mostly represented by the movements of the fingers (moving, squeezing, rubbing, etc.), moving the edges of clothes, belts, buttons, less often – earrings in the ears, rubbing the nose, wiping the lips. Of the other motility complexes, sighs with sucking in combination with gestures of embarrassment, facial expressions of helplessness, suffering were noted.

At a moderate depressive episode complexes from ethological elements, difficult motor chains of transitions quite often are formed though they can meet and independently. Locomotor movements are characterized by a general poverty of movements, their low expressiveness, although this is what creates the peculiarity of the locomotion of depression. The motility of the head, shoulders, arms, legs and torso is not just slowed down, but as if restrained, disharmonious, which creates whimsy, awkward gait and participation of the

extremities. Patients prefer old, worn-out things, try to dress invisibly, vaguely with a tendency to stereotypes of dressing, combing, washing, which is often ritual in nature and is done by inertia. There is no interest in changing your appearance. There is no delay in front of the mirror, although the ritual maintenance of cleanliness of body and clothing is preserved. The desire for comfortable behavior is reduced. Imitation behavior did not occur eating behavior of MG is significantly different from the behavior of CG; no licking, chewing movements, swallowing, touching a finger or object to the lips, movements of the oral area outside the tongue, manipulation of food items. Demonstrations of trust and obedience are sharply reduced by postures of obedience, gestures of obedience and submission, with a decrease or absence of etiquette of greeting and farewell. Decreased search behavior was noted as the avoidance of new meetings, acquaintances, new subjects. The behavior of attention and contact is manifested in the consolidation of attention with a constant fixation of the gaze on the hands of the interlocutor or their own, with a decrease in attention. There is no dominance behavior. Territorial behavior is characterized by loss of interest in another's territory, passive interest in familiar territory. Incomplete complexes of behavior of intentions such as intentions to speak, to greet, to start eating, to cry are characteristic. Most complex individual behaviors are ritual in nature, most often associated with posture, gesture, facial expressions, clothing. Severe manifestations of depression were characterized by sad and mournful facial expressions, lowered corners of the mouth, quiet voice, motor retardation, facial expressions of suffering, guilt, shame.

Analysis of nonverbal behavior in G1 and G2 will reveal the following features characteristic of each group.

In endogenous depression, all postures that are virtually uncommon in mentally healthy individuals have been identified: fixation postures, reflection, standing aggression, and coachman postures, submission, embryo, rider, concentration, and prayer. The predominance of out-of-doctor vision of varying duration. The whole group was characterized by lowering of the corners of the mouth and trembling of both or one of the corners of the mouth with yawning and licking. Very characteristic sad eyebrows with a Veraguth’s fold, horizontal or vertical wrinkles. The hands are fixed on the thighs or knees, the palms of the hands are locked, squeezing each other, intertwining and unraveling, tapping on each other.The torso, shoulders and head are often tilted forward. Individual distance has a desire to increase compared to the CG, without a desire to reduce both in a standing position and in a sitting position. The most common direct orientation in contact with a doctor, although in 13 patients G1 – lateral. The whole group is characterized by "typical" depressive facial

expressions: facial expressions of suffering, guilt, helplessness, hypomimia, rarely misunderstanding and pensiveness. In 19 patients forced, standard, "glued", sad facial expressions of a smile are noted. Eye contact is more often fixed on one's own body and directed downwards. The whole group of patients with endogenous depression is characterized by the following typology of gestures: treatment, obedience, contemplation, elimination, disgust, embarrassment, gesture of latent anxiety. For all gestures in the dynamics there is a replacement of eye and facial contact with a doctor to minimize contact, avoid contact and replace with gestures of obedience, thoughtfulness and elimination. The so-called "tired head" is characteristic, less often – nods. Shoulder and torso motility is included in the general change in patients' motility: reduction of shoulder response, distortion of orientation, tilt, elimination in combination with tremor with external stimuli.

According to the same scheme, the analysis of NB in psychogenic depression was carried out, among the elements of motor acts was the following: sitting and catching the patient standing is possible only in the process of moving to the doctor's office, and so on. If the doctor's office "does not have the opportunity" to sit, the patient may remain standing in a position of submission and reflection. In a sitting position, relaxed postures of the coachman, meditation, submission, rider, rarely praying and concentrating are preferred. Elementary units of facial expressions are very rich, diverse, easy to change and depend mainly on external stimuli, including the doctor, but are particularly sensitive to verbal stimuli. Very characteristic is the look in the face of the doctor, in which the call, begging for help, seeking compassion and empathy. And it's not just a look at the doctor's face, it's a search for his eyes. The duration of vision in the eyes of a doctor is higher than in mentally healthy people. The mouth is actively involved in facial expressions, most often trembling lips, corners of the mouth, less often – licking, sometimes with anxiety, the lips are compressed. In the process of communication, the mouth area may show elements of a smile. Eyebrows are often frowning and sad, often with wrinkles on the forehead, often horizontal. Veragut's folds did not meet. Eyelids are often swollen as evidence of recent crying or tears. Tears can flow without crying. Very long tears and facial expressions of crying. It is often observed to lay hands in front of a doctor, mostly "locked" and the same outside the legs. Elements of the torso, shoulders and head together with the limbs create the poses described above. Patients were "stuck" in the door of the doctor's office and slowly reduced the distance between the patient and the doctor.Greeting with separation is less common than in the CG, with the preservation of weak gestures and facial expressions. In the process of communication, patients preferred lateral orientation, without changing it and not seeking more comfortable orientation, even after

direct verbal stimulation. Characteristic hypomimia, which changes when communicating facial expressions of suffering, guilt, fear, crying, rarely sad smile, eye contact is most pronounced in combination with intense suffering, with a desire to "read" in the eyes of the doctor compassion and understanding. Simple actions are accompanied by gestures of behavior, obedience, embarrassment, latent anxiety. Of the simple motility complexes of the head, shoulders and torso, the most pronounced are the tilt or lowering of the head forward, the erection of the shoulders, less often – the coverage of the shoulders or shoulders, sometimes their twitching. There is manipulation of fingers, hair, earlobe (earring), the edge of clothing, less rubbing, kneading hands (fingers) or moving anything on the doctor's desk. Patients did not have simulated behavior. Eating behavior is characterized by a long period of preparation for eating, there is licking, swallowing, chewing movements without food in the mouth. Patients are willing to show trust and obedience to the doctor with facial expressions and gestures of submission, pleading, obedience, rarely helplessness.

Research behavior is reduced and focused on the doctor, his desk, facial expressions, hands and gestures. Behavior of attention is manifested by a stable fixation of the gaze on the doctor with facial expressions and orientation in search of trust and empathy. Communication is focused on the doctor; foreign stimuli do not distract the patient. Dominance behavior was not observed. Characteristic of the narrowing of territorial behavior, the desire is in a familiar situation. Changing the territory causes facial expressions and gestures of dissatisfaction, anxiety, tension, guilt, sighs. Patients seek to continue contact with the doctor with the intention of verbal communication. Of the simple complexes of NB can be called a slow desire to reduce the individual distance. Greetings at a distance do not differ from those in the CG.

Comparison of communication channels of endogenous and psychogenic depression shows, regardless of the option, there is a dependence on the depth and duration of depression. The easier the depressive episode, the more diverse facial expressions, more expressive gestures and brighter posture, i.e. through all three channels of communication, they are close to those of mentally healthy people.

Another picture is marked by the characteristics of the gesture, where the minimum degree of diversity is observed in the mentally healthy, due to the restraint of the gesture, especially at the first meeting. The posture channel in the mentally healthy is less restrained than the gesture, but less pronounced in stereotypes than in patients with depression. The channel of facial expressions is most pronounced in mentally healthy people, but, unlike patients, it corresponds more to the external emotional situation than to the internal emotional

state. The degree of reduction of activation through communication channels increases in the direction of mentally healthy – moderate depressive episode, due to psychogenic, to endogenous depression, which can be explained by the degree of involvement of relevant brain structures: cortical with reduced activation in the gesture activation in the pose channel.

Conclusions

1. As a result of the study, psychopathological and clinical-ethological features of the manifestations of the primary depressive episode were established and a comparative analysis of endogenous and psychogenic variants of the primary depressive episode was performed.

2. At contact with patients with the primary depressive episode there was a weakening or disintegration of attention and contact, the transition to other behaviors, including food and search. Characteristic is the increase in individual distance, lack of greetings in the distance, the location of the body in a lateral position; hypomimia, facial expressions of suffering, guilt, sadness; dissociated forms of smile; avoid eye contact; gestures of obedience and detachment.

3. For patients with mild and moderate severity of the primary depressive episode are characterized by: sad look, poses of reflection, submission, concentration in combination with facial expressions of suffering, guilt, helplessness, pensiveness, sideways, wrinkles on the forehead, stereotyped hand movements, head, head, reducing the synchronicity of gestural, facial and motor components of motility; avoidance of contacts and a sharp decrease in reactions to external influences. Severe manifestations of depression are characterized by sad and mournful facial expressions, lowered corners of the mouth, quiet voice, motor retardation, facial expressions of suffering, guilt and shame.

4. For patients with endogenous depression, were characterized by: Veragut's folds, bent shoulders and lowered head, reduced or no harmony of gestural, facial and motor components, eye contact, tendency to subordination, in contrast to psychogenic variants, which were characterized by constant visual contact, harmony and dependence of facial expressions, gestures and motor components on both affect and personal reactions.

5. The ethological component of the clinical-psychopathological method, based on the description of nonverbal behavior, can significantly improve the diagnostic capabilities of early detection of depressive episode, provides additional tools for typological differentiation and severity of patients with primary depressive episode.

Prospects for further research are to create an integrative system for diagnosing the first detected depressive episode using data from neurophysiological, clinical, ethological and experimental psychological components.

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