ANXIETY DISORDERS

Agoraphobia

DSM-5-TR 300.22 | ICD-10-CM F40.00

Fear of situations where escape may be difficult or help unavailable if panic-like or incapacitating symptoms occur.

12-MONTH PREVALENCE	TYPICAL ONSET	SEX RATIO	COURSE
~1.7% (US adults)	Late teens to mid-30s	2:1 female:male	Persistent; can be housebound

CLINICAL PICTURE

- Avoidance spans public transportation, open spaces, enclosed spaces, standing in line or in crowds, and being outside the home alone.
- Patients map the world by escape routes: aisle seats, positions near exits, short checkout lines, and roads with frequent turnoffs.
- A trusted companion often makes otherwise impossible outings tolerable, which masks true severity from family and from clinicians.
- Feared outcomes include panic, falling, incontinence, vomiting, or fainting in public with no one available to help or intervene.
- Progressive constriction of range can end in housebound status, which a substantial minority of severe untreated cases eventually reach.
- Employment, medical appointments, and caregiving collapse first, so referral frequently arrives through family or a primary care visit.

DIAGNOSTIC CRITERIA AT A GLANCE

- Marked fear or anxiety about at least two of five situations: public transport, open spaces, enclosed spaces, lines or crowds, and being alone outside.
- The person fears these settings because escape might be difficult or help unavailable if panic-like or embarrassing symptoms develop.
- Situations almost always provoke fear, require a companion, or are avoided outright, and the fear is disproportionate to actual danger.
- Persistent for **six months or more**, with clinically significant distress or impairment in social and occupational functioning.
- Now a standalone DSM-5-TR diagnosis; code both **agoraphobia** and panic disorder when full criteria for each are independently met.

NEUROBIOLOGY & PHYSIOLOGY

- Shares the amygdala, insula, and brainstem fear circuitry of panic disorder, with added hippocampal contextual encoding of specific places.
- Insular interoceptive prediction error signaling binds body sensations to spatial context, generating situation-specific threat expectancies.
- Heritability is estimated near **50-60%**, higher than most anxiety disorders, with substantial genetic overlap with panic disorder.
- Vestibular abnormalities and visual dependence are overrepresented and contribute to space and motion discomfort in wide open areas.
- Chronic HPA axis activation, deconditioning from inactivity, and disrupted circadian light exposure compound physical decline over time.
- Neuroimaging shows deficient ventromedial prefrontal extinction signaling, matching the poor generalization of safety learning seen clinically.

PSYCHOLOGICAL MECHANISMS

- Classical conditioning of place cues to panic, followed by operant maintenance through escape and avoidance that terminate anxiety immediately.
- Fear of fear plus low perceived self-efficacy for coping away from home drives steady generalization to new locations and situations.
- Safety signals such as a companion, phone, water bottle, or pill bottle preserve the belief that catastrophe was averted only by their presence.
- Interpersonal reinforcement is common: partners who accompany the patient or run every errand unintentionally sustain the avoidance.
- Attachment insecurity and early separation experiences increase reliance on proximity to a safe person as the primary emotion regulator.

DIFFERENTIAL & COMORBIDITY

- Differentiate from specific phobia (a single situation), social anxiety (evaluation), PTSD (trauma cues), and depression-related withdrawal.
- Rule out vestibular disease, orthostatic hypotension, cardiac syncope, and epilepsy before attributing situational avoidance to anxiety alone.
- Panic disorder co-occurs in a large majority of cases, with major depression and alcohol use disorder following closely behind.
- Housebound patients show high rates of vitamin D deficiency, physical deconditioning, and untreated chronic medical conditions.
- Suicidal ideation rises with the duration and severity of confinement, so ask directly even when the presentation looks purely phobic.

Treatment EVIDENCE-BASED MANAGEMENT

PHARMACOLOGIC

- **SSRIs** are first-line, mirroring panic disorder: **sertraline 25-200 mg/day** or **escitalopram 5-20 mg/day**, titrated slowly from a low start.
- **Venlafaxine XR 75-225 mg/day** is an appropriate alternative when SSRI response remains inadequate after **8-12 weeks** at target dose.
- Medication reduces panic frequency more reliably than it reduces avoidance, so exposure remains necessary to reclaim daily function.
- Benzodiazepines taken situationally before outings quickly become safety behaviors and blunt the extinction learning exposure depends on.
- Continue an effective medication for **at least 12 months** after remission, then taper across months to limit relapse and rebound.

PSYCHOTHERAPY

- **In-vivo exposure** to feared locations conducted without companions or safety objects is the definitive intervention for agoraphobia.
- **CBT** over **12-20 sessions** with hierarchy construction, cognitive work, and therapist-accompanied field trips is the standard protocol.
- Fading the companion and the carried safety object explicitly, step by step, produces the largest gains in real-world functioning.
- **Virtual reality exposure** and app-guided field exposure help initiate treatment for patients who are already largely housebound.
- Home-based and telehealth-delivered exposure programs reach patients who cannot physically attend a clinic to begin treatment at all.

ADJUNCT & SUPPORTIVE

- Enlist family to stop accommodating and convert the driving partner into an exposure coach working from a written, agreed plan.
- Track weekly with the **Mobility Inventory for Agoraphobia** plus a simple log of independent trips taken and distance traveled.
- Rebuild physical conditioning gradually, since deconditioned patients misread exertional tachycardia as the onset of another attack.
- Address the backlog of vitamin D, dental, and preventive care created by years of avoiding appointments outside the home.
- Escalate to intensive outpatient or home-visit programs when housebound status persists despite an adequate course of outpatient **CBT**.

CLINICAL PEARLS

- Agoraphobia stands alone in DSM-5-TR; diagnose it separately even when panic disorder is present.
- Ask who comes with you and what you carry; both answers name the safety behaviors to fade first.
- Medication reduces panic but rarely restores mobility; exposure is what gives the world back.

Aligned to DSM-5-TR (APA, 2022) · Educational reference only — not a substitute for clinical judgment or full diagnostic assessment.

References

American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders* (5th ed., text rev.). https://doi.org/10.1176/appi.books.9780890425787

Bandelow, B., Michaelis, S., & Wedekind, D. (2017). Treatment of anxiety disorders. *Dialogues in Clinical Neuroscience, 19*(2), 93-107. https://doi.org/10.31887/DCNS.2017.19.2/bbandelow

Craske, M. G., & Stein, M. B. (2016). Anxiety. *The Lancet, 388*(10063), 3048-3059. https://doi.org/10.1016/S0140-6736(16)30381-6

National Institute for Health and Care Excellence. (2020). *Generalised anxiety disorder and panic disorder in adults: Management* (NICE Guideline CG113). https://www.nice.org.uk/guidance/cg113

National Institute of Mental Health. (n.d.). *Anxiety disorders*. U.S. Department of Health and Human Services. https://www.nimh.nih.gov/health/topics/anxiety-disorders

Roy-Byrne, P. P., Craske, M. G., & Stein, M. B. (2006). Panic disorder. *The Lancet, 368*(9540), 1023-1032. https://doi.org/10.1016/S0140-6736(06)69418-X

Sadock, B. J., Sadock, V. A., & Ruiz, P. (2021). *Kaplan & Sadock's synopsis of psychiatry* (12th ed.). Wolters Kluwer.

Stahl, S. M. (2021). *Stahl's essential psychopharmacology* (5th ed.). Cambridge University Press.

NOTE

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