

**Comprehensive Research Report on Agoraphobia**

**Disorder Name**

Agoraphobia [[1]](#fn1)

**Source (Textbook Title + Edition)**

* Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR) [[1]](#fn1)[[2]](#fn2)
* International Classification of Diseases, Eleventh Revision (ICD-11) [[3]](#fn3)

**Classification Codes**

**ICD Code**

ICD-11: 6B02 [[3]](#fn3)[[4]](#fn4)

**DSM Code**

DSM-5-TR: 300.22 (F40.00) [[1]](#fn1)[[5]](#fn5)

**Diagnostic Criteria**

**DSM-5-TR Criteria**

To meet DSM-5-TR criteria for agoraphobia, patients must have marked, persistent (≥ 6 months) fear of or anxiety about 2 or more of the following situations [[1]](#fn1):

* Using public transportation
* Being in open spaces (e.g., parking lot, marketplace)
* Being in an enclosed place (e.g., shop, theater)
* Standing in line or being in a crowd
* Being alone outside the home

Additional requirements include [[1]](#fn1):

* The same situations nearly always trigger fear or anxiety
* Patients actively avoid the situation and/or require the presence of a companion
* The fear or anxiety is out of proportion to the actual threat
* The fear, anxiety, and/or avoidance cause significant distress or significantly impair functioning
* If another medical condition is present, the fear, anxiety, and/or avoidance are clearly excessive

**ICD-11 Criteria**

Agoraphobia is characterized by marked and excessive fear or anxiety that occurs in response to multiple situations where escape might be difficult or help might not be available [[3]](#fn3). The individual is consistently anxious about these situations due to a fear of specific negative outcomes (e.g., panic attacks, other incapacitating or embarrassing physical symptoms) [[3]](#fn3).

**Duration Required for Diagnosis**

DSM-5-TR requires symptoms to be persistent for at least 6 months [[1]](#fn1). ICD-11 specifies that symptoms must persist for at least several months [[3]](#fn3).

**Exclusion Criteria / Rule-Outs**

The fear and anxiety cannot be better characterized as a different mental disorder such as social anxiety disorder or body dysmorphic disorder [[1]](#fn1). If another medical condition is present (e.g., inflammatory bowel disease, Parkinson disease), the fear, anxiety, and/or avoidance must be clearly excessive [[1]](#fn1).

**Common Differential Diagnoses**

* Social anxiety disorder (social phobia) [[6]](#fn6)
* Panic disorder without agoraphobia [[6]](#fn6)
* Specific phobias [[1]](#fn1)
* Body dysmorphic disorder [[1]](#fn1)
* Post-traumatic stress disorder [[1]](#fn1)

**Common Comorbidities**

Agoraphobia has high comorbidity with [[7]](#fn7):

* Other anxiety disorders
* Major depressive disorder
* Post-traumatic stress disorder (PTSD)
* Alcohol use disorder
* Panic disorder

Approximately 15% of patients diagnosed with agoraphobia report suicidal thoughts or behavior [[7]](#fn7). For those with comorbid major depressive disorder, agoraphobia is more treatment-resistant compared to those with agoraphobia alone [[7]](#fn7).

**Specifiers / Subtypes**

The DSM-5-TR does not specify formal subtypes for agoraphobia, but research has identified early-onset (≤27 years) versus late-onset (>27 years) patterns [[8]](#fn8). Early onset agoraphobia appears to constitute a familial subtype associated with family history of anxiety disorders [[8]](#fn8).

**Severity Levels**

The DSM-5 Severity Measure for Agoraphobia-Adult uses a 10-item scale with total scores ranging from 0 to 40, with higher scores indicating greater severity [[9]](#fn9)[[10]](#fn10). The average total score categorizes severity as none (0), mild (1), moderate (2), severe (3), or extreme (4) [[9]](#fn9).

**Age of Onset**

Agoraphobia often develops in adolescence and young adulthood, but can also develop in older adults [[1]](#fn1). Research identifies 27 years as the optimal cutoff age distinguishing early-onset from late-onset agoraphobia [[8]](#fn8). Symptoms can begin in childhood but typically start in late teens or early adult years [[11]](#fn11).

**Gender Prevalence**

Agoraphobia affects approximately 2% of the population in a given year and is more common in women [[1]](#fn1). The female-to-male ratio ranges from 1.6-3.1, meaning women are between one and one-half times and three times more likely to have agoraphobia than men [[12]](#fn12). Women also tend to have more severe symptoms and experience more impairment from agoraphobia than men [[12]](#fn12).

**Typical Course/Progression**

Agoraphobia tends to be a chronic illness if left untreated [[13]](#fn13). At 1 year follow-up, there is a 0.39 probability of full remission for uncomplicated panic disorder versus 0.17 probability for panic disorder with agoraphobia [[14]](#fn14). The condition has a chronic course with high rates of relapse after remission and longer episodes when agoraphobia is part of the symptom constellation [[14]](#fn14).

**Core Symptoms**

Core symptoms include [[15]](#fn15)[[16]](#fn16):

* Marked fear or anxiety about two or more agoraphobic situations
* Fear that escape might be difficult or help unavailable if panic-like symptoms develop
* Active avoidance of situations or requiring a companion
* Situations almost always provoke fear or anxiety

**Cognitive Features**

Cognitive symptoms include fears that [[16]](#fn16):

* A panic attack will make one look stupid or feel embarrassed
* A panic attack will be life-threatening
* One would be unable to escape from a place or situation during a panic attack
* One is losing sanity or may lose control in public
* People may stare at them

Additional cognitive features include feeling unable to function without help from others and general feelings of anxiety or dread [[16]](#fn16)[[17]](#fn17).

**Emotional Symptoms**

Emotional symptoms encompass [[17]](#fn17)[[18]](#fn18):

* Intense fear of leaving home alone
* Fear of losing control in public settings
* Excessive worry about experiencing panic attacks in public
* Feeling detached from reality or others
* Fear of embarrassment or losing control in public
* Constant worry about potential panic attacks

**Behavioral Symptoms**

Behavioral symptoms include [[16]](#fn16)[[17]](#fn17):

* Avoiding situations that could lead to panic attacks (crowded places, public transport, queues)
* Being housebound for long periods
* Needing to be with someone trusted when going anywhere
* Avoiding being far away from home
* Moving away from situations early or remaining close to exits

**Somatic/Physical Symptoms**

Physical symptoms are similar to panic attacks and include [[16]](#fn16)[[17]](#fn17):

* Fast heartbeat and palpitations
* Fast breathing (hyperventilation)
* Feeling hot and sweaty
* Chest pain or discomfort
* Trembling or shaking
* Dizziness and lightheadedness
* Nausea or abdominal distress
* Difficulty swallowing
* Ringing in ears (tinnitus)

**Insight / Awareness of Illness**

Most individuals with agoraphobia retain insight that their fear is excessive and disproportionate to the actual danger posed by the situations [[1]](#fn1)[[3]](#fn3). However, the fear persists despite this awareness.

**Cultural Considerations in Presentation**

Cultural factors significantly influence agoraphobia presentation [[19]](#fn19). In Chinese populations, a unique theme of "fear of making others worried and being a burden to others" has been identified [[19]](#fn19). Individualistic versus collectivistic cultural orientations affect symptom presentation, with subjects from individualistic cultures more likely to experience depersonalization and fear of losing control during panic attacks [[19]](#fn19).

**Genetic Factors**

Heritability in agoraphobia is remarkably high at 61% according to DSM-5-TR [[20]](#fn20). The disorder tends to run in families, with genetic factors playing a significant role in risk development [[17]](#fn17)[[20]](#fn20). Research has identified genetic factors that predispose to broad groups of anxiety disorders, including agoraphobia [[21]](#fn21).

**Neurobiological Factors**

Neuroimaging studies reveal that patients with panic disorder and agoraphobia show stronger activations in the bilateral ventral striatum and left insula when anticipating agoraphobia-specific stimuli compared to controls [[22]](#fn22). Hyperactivation of the ventral striatum and insula when anticipating agoraphobic situations appears to be a central neurofunctional correlate of agoraphobia [[22]](#fn22).

**Psychological Factors**

Key psychological factors include [[17]](#fn17)[[20]](#fn20):

* Extreme introversion
* Anxiety sensitivity (belief that physical symptoms of anxiety are dangerous)
* Avoidant and dependent personality traits
* Temperamental factors involving frequent negative emotions
* Catastrophic cognitions about panic symptoms

Research indicates that anxiety in agoraphobia is driven by catastrophic cognitions, making these useful therapeutic targets [[23]](#fn23).

**Environmental / Social Factors**

Environmental risk factors include [[17]](#fn17)[[20]](#fn20):

* Negative childhood experiences such as losing a parent or separation from caregivers
* Traumatic events like being attacked or robbed in public
* Growing up in families that are overly protective or lack emotional warmth
* History of panic attacks leading to avoidance behaviors

**Cultural / Religious Factors**

Cultural factors affect symptom expression and help-seeking behaviors [[19]](#fn19). In collectivistic cultures, concerns about affecting family members and being a burden are prominent features [[19]](#fn19). Religious and spiritual practices may serve as coping mechanisms but require culturally sensitive assessment [[19]](#fn19).

**Developmental History**

Agoraphobia can develop after experiencing intense anxiety or panic attacks [[18]](#fn18). The fear of these episodes occurring in public or unfamiliar places leads to avoidance behaviors that reinforce anxiety over time [[18]](#fn18). Early onset (≤27 years) is associated with family history of anxiety disorders [[8]](#fn8).

**Family History**

Family history of anxiety disorders is a significant risk factor, particularly for early-onset agoraphobia [[8]](#fn8). The disorder shows strong familial clustering with high heritability estimates [[20]](#fn20).

**Assessment Measures**

**Structured Interviews**

* Structured Clinical Interview for Panic-Agoraphobic Spectrum (SCI-PAS) - 114 items organized into nine domains [[24]](#fn24)
* Anxiety Disorders Interview Schedule (ADIS) [[25]](#fn25)

**Self-Report Measures**

* DSM-5 Severity Measure for Agoraphobia-Adult (10 items, 5-point Likert scale) [[9]](#fn9)[[10]](#fn10)
* Oxford Agoraphobic Avoidance Scale (8-item questionnaire with avoidance and distress scales) [[26]](#fn26)

**Clinician-Rated Scales**

* Clinical Global Impression scales [[27]](#fn27)
* Panic disorder severity measures [[27]](#fn27)
* Agoraphobia severity ratings [[27]](#fn27)

**Psychometric Tools**

Assessment tools focus on measuring avoidance behaviors, distress levels, and functional impairment [[26]](#fn26). The Oxford Agoraphobic Avoidance Scale demonstrates excellent psychometric properties with clinical cut-offs and score ranges provided [[26]](#fn26).

**Observation Methods**

Behavioral avoidance tasks (BATs) provide objective assessment of avoidance and in situ anxiety but are challenging to administer and lack standardization [[26]](#fn26).

**Lab / Neuroimaging Considerations**

Neuroimaging using fMRI can reveal disorder-specific neural alterations, particularly hyperactivation in ventral striatum and insula during anticipation of agoraphobic stimuli [[22]](#fn22). However, these are primarily research tools rather than clinical diagnostic methods.

**Pharmacological Treatments**

**First-Line Pharmacological Treatments**

Selective serotonin reuptake inhibitors (SSRIs) are the first-line pharmacological treatment [[1]](#fn1)[[28]](#fn28). Commonly used SSRIs include:

* Fluoxetine
* Citalopram
* Paroxetine
* Fluvoxamine
* Sertraline

**Alternative Pharmacological Options**

* Serotonin-norepinephrine reuptake inhibitors (SNRIs) such as venlafaxine [[29]](#fn29)
* Benzodiazepines (short-term use) [[30]](#fn30)[[31]](#fn31)
* Tricyclic antidepressants [[32]](#fn32)

**Medication Side Effects**

SSRI side effects may include initial anxiety symptoms when starting treatment [[29]](#fn29). Benzodiazepine side effects include sedation, fatigue, ataxia, slurred speech, amnesia, and potential for dependence [[30]](#fn30)[[31]](#fn31). More serious adverse reactions can include depression, disinhibition, and aggressive behavior [[30]](#fn30).

**Medication Monitoring Requirements**

Patients with agoraphobia and panic disorder typically require higher doses and longer treatment periods to achieve full response [[29]](#fn29). Close monitoring is needed for side effects, particularly when initiating treatment, as some medications can initially increase anxiety symptoms [[29]](#fn29).

**Psychotherapy**

**Recommended Psychotherapy Modalities**

Cognitive-behavioral therapy (CBT) with exposure therapy is the most effective treatment approach based on robust evidence [[1]](#fn1)[[33]](#fn33). Specific modalities include:

* In-vivo exposure therapy
* Interoceptive exposure therapy
* Systematic desensitization

**Core Therapeutic Goals**

* Eliminate or significantly reduce avoidance behaviors
* Increase tolerance of anxiety-provoking situations
* Challenge catastrophic cognitions
* Improve overall functioning and quality of life
* Achieve independence in daily activities

**Therapist Role/Approach**

Therapists guide gradual exposure to feared situations using CBT principles [[1]](#fn1). The approach involves creating individualized exposure hierarchies and helping patients develop coping strategies [[33]](#fn33). Supportive but challenging therapeutic stance is essential [[25]](#fn25).

**Common Challenges in Treatment**

* High levels of avoidance making engagement difficult
* Family accommodation behaviors that maintain symptoms [[25]](#fn25)
* Resistance to exposure exercises
* High dropout rates without proper preparation
* Managing safety behaviors and escape routes

**Prognosis with Treatment**

CBT produces significant improvement, but maintenance therapy may be needed to prevent relapse [[27]](#fn27). Exposure treatment can provide lasting relief to the majority of patients with panic disorder and agoraphobia [[34]](#fn34). Long-term follow-up shows 93.1% remaining in remission after 2 years, 82.4% after 5 years, and 62.1% after 10 years [[34]](#fn34).

**Lifestyle Considerations**

**Sleep and Nutrition Considerations**

A varied and balanced diet is important as poor nutrition can impact energy levels and sleep, which in turn affects mood [[35]](#fn35). Adequate sleep hygiene supports overall mental health and treatment outcomes [[35]](#fn35).

**Exercise and Movement**

Regular exercise can aid in alleviating stress and contribute to mood improvement [[35]](#fn35). Even light activities like stretching or walking can be beneficial, though individuals may find it difficult to exercise when feeling unwell [[35]](#fn35).

**Mindfulness / Spiritual Practices**

Relaxation techniques and mindfulness practices are commonly incorporated into treatment [[29]](#fn29). These practices can help manage anxiety symptoms and improve coping skills [[13]](#fn13).

**Social Support and Structure**

**Community or Social Support Needs**

Partner-assisted exposure therapy has shown effectiveness in reducing symptoms [[13]](#fn13). Family members can provide crucial support by encouraging exposure practice and offering emotional support [[13]](#fn13).

**Routine and Structure Guidance**

Maintaining consistent routines and gradually expanding comfort zones through structured exposure can be beneficial [[13]](#fn13). Having trusted companions initially can help transition to independent functioning [[13]](#fn13).

**Special Populations**

**Children & Adolescents**

Agoraphobia can develop in adolescence, often requiring family-based interventions [[25]](#fn25). Combined approaches addressing both individual CBT and family accommodation patterns show promise [[25]](#fn25).

**Older Adults**

Agoraphobia can develop in older adults, especially in the context of fears about safety and physical limitations [[1]](#fn1). Treatment may need modification to account for mobility issues and health concerns [[1]](#fn1).

**Pregnancy & Postpartum**

Special considerations are needed for medication safety during pregnancy and breastfeeding [[1]](#fn1). CBT may be preferred during these periods to avoid potential medication risks [[1]](#fn1).

**LGBTQIA+ Considerations**

LGBTQ individuals face higher rates of anxiety disorders including agoraphobia due to discrimination and minority stress [[36]](#fn36). Culturally competent care and LGBTQ-affirming therapy approaches are essential [[36]](#fn36).

**Risk Management**

**Substance Use Complications**

Agoraphobia shows comorbidity with alcohol use disorder [[7]](#fn7). Substances may be used for self-medication but can worsen symptoms long-term [[35]](#fn35). Avoiding alcohol and drugs is recommended during treatment [[35]](#fn35).

**Suicidality / Risk Management**

About 15% of patients with agoraphobia report suicidal thoughts or behavior [[7]](#fn7). Panic-agoraphobic comorbidity is associated with greater risk for suicidality beyond the effects of depression alone [[37]](#fn37). Comprehensive screening for suicidality is essential [[37]](#fn37).

**Long-term Management**

**Early Warning Signs of Relapse**

Common early warning signs include [[38]](#fn38):

* Changes in sleeping patterns
* Lack of self-care
* No longer taking medication as prescribed
* Social withdrawal
* Return of worries or preoccupations
* Difficulty keeping commitments
* No longer engaging in enjoyable activities

**Maintenance Treatment Options**

Monthly maintenance CBT significantly reduces relapse rates (5.2%) compared to assessment only (18.4%) [[27]](#fn27). Maintenance therapy is particularly important for patients with residual agoraphobic symptoms after acute treatment [[27]](#fn27).

**Prognostic Indicators**

**Good Prognostic Indicators**

* Younger age at treatment [[34]](#fn34)
* Absence of personality disorders [[34]](#fn34)
* Absence of high pre-treatment depressed mood [[34]](#fn34)
* Complete elimination of residual agoraphobic avoidance [[34]](#fn34)
* Early treatment engagement [[34]](#fn34)

**Poor Prognostic Indicators**

* Presence of residual agoraphobic avoidance after treatment [[27]](#fn27)[[34]](#fn34)
* Concurrent use of benzodiazepines and antidepressants [[34]](#fn34)
* High pre-treatment levels of depression [[34]](#fn34)
* Presence of personality disorders [[34]](#fn34)

**Typical Recovery Timeframes**

Acute CBT typically lasts 12-16 sessions over 3-4 months [[32]](#fn32)[[34]](#fn34). Long-term outcomes show sustained improvement is possible, with maintenance therapy lasting 9 months showing significant benefits [[27]](#fn27).

**Recurrence Rates**

Research indicates 23% of patients experience relapse during long-term follow-up [[34]](#fn34). However, with proper maintenance treatment, relapse rates can be significantly reduced [[27]](#fn27).

**Patient and Family Education**

**Patient Education Recommendations**

* Psychoeducation about the nature of anxiety and panic [[25]](#fn25)
* Understanding the connection between avoidance and symptom maintenance [[25]](#fn25)
* Learning about exposure therapy principles and habituation [[25]](#fn25)
* Recognizing early warning signs of relapse [[38]](#fn38)

**Family Psychoeducation**

Family education should include [[25]](#fn25)[[13]](#fn13):

* Understanding anxiety symptoms and their impact on family systems
* Learning about family accommodation and how it maintains symptoms
* Distinguishing between protection and support
* Developing supportive communication strategies
* Encouraging independence while providing emotional support

The most effective approach combines evidence-based pharmacological and psychological treatments with comprehensive patient and family education, cultural sensitivity, and long-term maintenance strategies to achieve optimal outcomes for individuals with agoraphobia.

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