

**Differences Between DSM-5, ICD-11, and CDDR Criteria for Diagnosing Agoraphobia**

**Overview of Classification Systems**

The diagnosis of agoraphobia varies across three major classification systems used globally. The DSM-5 (Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition) is primarily used in the United States, while the ICD-11 (International Classification of Diseases, Eleventh Revision) serves as the international standard adopted by the World Health Organization [[1]](#fn1). The CDDR (Clinical Descriptions and Diagnostic Requirements for ICD-11 Mental, Behavioural and Neurodevelopmental Disorders) represents the clinical implementation guide for ICD-11, providing detailed diagnostic requirements for practitioners worldwide [[2]](#fn2)[[3]](#fn3).

**Fundamental Definitional Differences**

**DSM-5 Definition**

The DSM-5 defines agoraphobia as marked, persistent fear or anxiety about two or more of five specific situations: using public transportation, being in open spaces, being in enclosed places, standing in line or being in a crowd, and being alone outside the home [[4]](#fn4). The individual must fear these situations due to thoughts that escape might be difficult or help unavailable if panic-like symptoms develop [[4]](#fn4).

**ICD-11/CDDR Definition**

The ICD-11 CDDR characterizes agoraphobia as "marked and excessive fear or anxiety that occurs in response to multiple situations where escape might be difficult or help might not be available" [[5]](#fn5). The individual is consistently anxious about these situations due to fear of specific negative outcomes such as panic attacks or other incapacitating or embarrassing physical symptoms [[5]](#fn5).

**Duration Requirements: A Key Distinction**

**DSM-5 Duration Criteria**

The DSM-5 requires symptoms to be persistent for at least 6 months for an agoraphobia diagnosis [[4]](#fn4)[[6]](#fn6). This represents a significant change from DSM-IV, where the 6-month duration requirement was added specifically to enhance diagnostic reliability [[7]](#fn7).

**ICD-11/CDDR Duration Criteria**

In contrast, the ICD-11 CDDR specifies that symptoms must persist for "at least several months" rather than the precise 6-month threshold [[5]](#fn5). This reflects the ICD-11's philosophy of providing more flexible guidelines that allow clinicians to exercise professional judgment [[8]](#fn8).

**Structural and Hierarchical Differences**

**Diagnostic Independence**

A major structural difference lies in how agoraphobia relates to panic disorder. The DSM-5 treats agoraphobia as a completely separate diagnosis from panic disorder, allowing for dual diagnoses when both conditions are present [[6]](#fn6)[[7]](#fn7). This represents a significant change from DSM-IV, where agoraphobia was primarily conceptualized as subordinate to panic disorder [[9]](#fn9).

The ICD-11 CDDR similarly treats agoraphobia as an independent diagnostic entity, coded as 6B02, separate from panic disorder [[5]](#fn5)[[10]](#fn10).

**Specific Diagnostic Criteria Variations**

**Situation Requirements**

Both DSM-5 and ICD-11 require fear or anxiety in at least two situations from their respective lists of agoraphobic situations [[4]](#fn4)[[5]](#fn5). However, the ICD-11 provides slightly different examples, including "being in crowds or shopping malls" as specific instances [[5]](#fn5).

**Symptom Thresholds and Flexibility**

The DSM-5 employs more rigid criteria with specific symptom counts and duration thresholds [[8]](#fn8). For example, panic attacks in DSM-5 require "four or more" specific symptoms from a list of thirteen [[8]](#fn8).

The ICD-11 CDDR uses more flexible language, employing terms like "several" symptoms rather than specific numerical thresholds [[8]](#fn8). This approach allows clinicians greater discretion in applying diagnostic criteria to individual patients [[8]](#fn8).

**Exclusion Criteria Presentation**

The DSM-5 presents exclusion criteria as specific bullet points (C and D criteria), clearly delineating when the diagnosis should not be made due to substance effects or other medical conditions [[8]](#fn8).

The ICD-11 CDDR incorporates these same concepts within a section called "boundary with other disorders or normality" rather than as separate exclusion criteria [[8]](#fn8). This structural difference reflects the CDDR's emphasis on clinical judgment over rigid rule application.

**Cultural and Implementation Considerations**

**Cultural Sensitivity**

The ICD-11 CDDR places greater emphasis on cultural considerations in diagnosis, providing "culture-related guidance for each disorder, including how disorder presentations may differ systematically by cultural background" [[2]](#fn2)[[3]](#fn3). This reflects the WHO's global perspective and need to accommodate diverse cultural presentations of mental health conditions.

**Clinical Implementation**

The CDDR serves as the clinical implementation guide for ICD-11, designed specifically for mental health professionals and primary care physicians who assign diagnoses in clinical settings [[1]](#fn1)[[2]](#fn2). It aims to support "accurate and reliable identification and diagnosis" across diverse global healthcare systems [[1]](#fn1).

**Diagnostic Coding Differences**

The diagnostic codes differ between systems: DSM-5 uses 300.22 (F40.00) [[11]](#fn11), while ICD-11 assigns code 6B02 [[5]](#fn5)[[10]](#fn10). These coding differences have practical implications for healthcare documentation, insurance billing, and international research comparisons.

**Research and Validation Implications**

The differences between these classification systems have been extensively studied. Research comparing DSM-5 and DSM-IV agoraphobia found that 57.1% of individuals met criteria in both systems, while 24.2% met DSM-5 criteria only and 18.8% met DSM-IV criteria only [[12]](#fn12). The CDDR underwent rigorous field testing involving over 1,800 patients across 13 countries, demonstrating reliability coefficients ranging from moderate to almost perfect [[13]](#fn13).

**Conclusion**

While DSM-5, ICD-11, and CDDR share core conceptual similarities in defining agoraphobia, they differ significantly in duration requirements, diagnostic flexibility, cultural considerations, and implementation approaches. The DSM-5 emphasizes precise thresholds and specific timeframes, while the ICD-11 CDDR prioritizes clinical flexibility and cultural sensitivity. These differences reflect distinct philosophical approaches to psychiatric diagnosis and have important implications for clinical practice, research, and international collaboration in mental health care.

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