Patient

View this article online at: patient.info/doctor/agoraphobia-pro

Agoraphobia

What is agoraphobia?[1]

Agoraphobia is often thought of as a fear of open spaces. However, a better definition is a fear of being in a situation (often involving people) where escape is difficult, or help is not available. Being in this type of provoking situation usually leads to an anxiety attack.

There are three basic elements:

- Phobia.
- Avoidance of situations that might provoke the anxiety.
- Severe anxiety.

It can involve a number of phobias which may overlap - eg, presence of crowds or travelling alone. Once patients are in the provoking situation, they develop sudden and severe anxiety - the anxiety is what they try to avoid. Some patients can manage to continue their daily lives (with difficulty), whilst others are severely affected and may even become incapacitated.

How common is agoraphobia? (Epidemiology)

- Epidemiological data in the UK are hard to find. A 2021 English study of 7,403 adults looked at psychiatric comorbidity in post-traumatic stress disorder and found 17.9% of those patients also had a diagnosis of agoraphobia.[2]
- One 2017 study of 65 to 84-year-olds in five European countries and Israel, found agoraphobia to be present in 4.9%.[3]
- Panic disorder is closely related to agoraphobia and has a lifetime prevalence of 1-5%.[4]

- One American study found agoraphobia to be the least common of the anxiety disorders.[5]
- Most studies find a female preponderance in anxiety disorders, but some say males and females are now similarly affected with agoraphobia.[1]
- The most common age of presentation is before 35 years.
- The 12-month prevalence of panic disorder/agoraphobia is about 6%.[6]
- The Diagnostic and Statistical Manual of Mental Disorders version 5 (DSM-5) states agoraphobia affects 1.7% of the general population.[1]

Diagnosis of agoraphobia[7]

Panic attacks and agoraphobia are underdiagnosed and therefore a high index of suspicion is required. DSM-IV did not recognise agoraphobia as a distinct entity, classifying it as a form of panic disorder. DSM-5 defines agoraphobia as:[1]

- Marked fear or anxiety about two or more of the following five groups of situations:
    - Public transportation - eg, travelling in cars, buses, trains, ships or planes.
    - Open spaces - eg, parking lots, market places or bridges.
    - Being in shops, theatres or cinemas.
    - Standing in line (queuing) or being in a crowd.
    - Being outside of the home alone in other situations.

The person fears or avoids these situations due to thoughts that escape might be difficult or help might not be available in the event of panic-like symptoms. The agoraphobic situations almost always provoke fear or anxiety. The situations are actively avoided, require presence of a companion, or are endured with marked fear or anxiety.

The fear or anxiety is out of proportion to actual danger posed by the agoraphobic situation. The fear, anxiety, or avoidance is persistent, typically lasting for six months or more. The fear, anxiety, or avoidance cause clinically significant distress or functional impairment.

High rates of agoraphobic-type avoidance have also been found in people with psychosis, social anxiety, panic disorder and post-traumatic stress disorder (PTSD).[8]

Differential diagnosis[1]

The differential diagnosis includes:

- Social anxiety disorder.
- Generalised anxiety disorder.
- Depression, post-traumatic stress disorder (PTSD).
- Physical disorders which cause reluctance to leave the home - eg, coronary heart disease.

Management of agoraphobia

Treatment options include psychological and pharmacological treatments. All patients should receive education about their disorder, efficacy (including expected time to onset of therapeutic effects) and tolerability of treatment choices, aggravating factors, and signs of relapse.[7]

There is no high-quality, unequivocal evidence to support one psychological therapy over the others.[9] There is also no strong evidence regarding the relative effectiveness of psychological therapies and pharmacological treatment.[10] Long-term outcomes after CBT may be less favourable than other anxiety-related disorders.[11]

The National Institute for Health and Care Excellence (NICE) recommends a stepped care approach.[12]

Step 1: recognition and diagnosis

This has been dealt with in the introductory section and the 'Diagnosis' section, above.

Step 2: treatment by the GP

General

- Try to establish a rapport with the patient.
- Assure them that you will treat them in a non-judgemental manner and will respect their confidentiality and privacy.
- Explore their worries in order to obtain a perspective on how the condition is affecting their life.
- Assure them that decision-making is a shared process and try to achieve a joint agreement as to the best way to manage the problem.
- Provide information (verbal and written) in a way the patient and their family/carers can understand. This should include contact numbers and information about what to do and who should be contacted in a crisis, as well as local and national self-help organisations and support groups, in particular where they can talk to others with similar experiences.
- Advise avoiding anxiety-producing substances - eg, caffeine.
- It is important to exclude alcohol or drug misuse as a factor and to treat these problems if present. Reassessment after successful management of substance-related issues will reveal if this is true panic disorder. Response to pharmacological/psychological therapies is likely to be poor in the face of alcohol/drug misuse or dependence.

Offer the following interventions (listed as per NICE in the order - according to the evidence base - of duration of efficacy):

- Refer for cognitive behavioural therapy (CBT). CBT can be as effective for elderly patients as for younger people.[13]
- Education - help the patient to understand the problem.
- Lifestyle changes - avoid alcohol and illicit drugs and stimulants.
- Self-help groups - focus on relaxation and breathing exercises.

Medication

Important information

General principles
Before prescribing, consider age, previous treatment, tolerability, other medication, comorbidities, personal preference, cost and risk of self-harm (selective serotonin reuptake inhibitors (SSRIs) are less dangerous than tricyclics in overdose).
Inform the patient about possible side-effects (including a temporary increase in anxiety at the start of treatment), delay in onset of effect, possible discontinuation symptoms, the length of treatment and the need to follow dosage instructions.
Provide written information appropriate to the patient's needs.
Start with a low dose to minimise side-effects.
Some patients may need long-term treatments and a dose at the upper end of the range.
Benzodiazepines are not recommended in guidelines as routine treatment for panic-type disorders because of their relatively high risk of adverse effects when compared to alternatives, such as SSRIs.[14] Despite this, they are still often used, usually to manage short-term crises, because of their rapid onset of action.

The following advice has been given by NICE for the management of panic disorder - with or without agoraphobia:[12]

- Antidepressant drugs have been shown to be effective in reducing the amplitude of panic, reducing frequency of, or eliminating, panic attacks and improving quality-of-life measures in this group of patients.
- Offer an SSRI licensed for this indication first-line unless contra-indicated.
- Consider imipramine or clomipramine if there is no improvement after 12 weeks and further medication is indicated (**NB**: neither is licensed for this indication in the UK, so document informed consent).
- Review the patient after two weeks to check for side-effects and efficacy, and at 4, 6 and 12 weeks.
- If there has been an improvement after 12 weeks, continue for 6 months after the optimum dose has been reached.

- If medication is used for longer than 12 weeks, review at 8- to 12-weekly intervals.
- Follow the summary of product characteristics of the individual drugs for other monitoring requirements.
- Use self-completed questionnaires to monitor outcomes where possible.
- At the end of treatment, withdraw the SSRI gradually, as dictated by patient preference; monitor monthly for relapse for as long as appropriate to the individual.

Self-help

- Give the patient details of books based on CBT principles; provide contact details of any available support groups. With the patient's permission, give relatives or carers details of support groups which can be useful in bolstering the patient's support network as well as patients themselves. There is evidence that self-help interventions are an effective option for people with panic disorder.[15]
- Promote exercise as part of good general health. There is some evidence of a reduction in anxiety symptoms following exercise. A systematic review suggested that the effect is not as great as antidepressants but it could be a useful adjunct.[16]
- Monitor the patient on a regular basis, usually every 4-8 weeks, preferably using a self-completed questionnaire.

Step 3
Reassess the condition and consider another intervention.

Step 4
If two interventions have been offered without benefit, consider referral to specialist mental health services. Specialist treatment may include management of comorbid conditions, structured problem solving, other types of medication and treatment at tertiary centres.

When should a GP consider urgent referral?
Consider urgent referral to mental health services if there is:

- A risk of self-harm or suicide.

- Significant comorbidity, such as substance misuse, personality disorder or complex physical health problems.
- Self-neglect.

Management may sometimes be complicated by the fact that the patient's condition prevents them from leaving the house to access treatment. If options cannot be selected which can be pursued at home (eg, self-help treatment), discuss the patient with mental health services. There may be local options (eg, domiciliary therapy by a community psychiatric nurse) which may be available.

Recently developed automated virtual reality CBT has shown promising results in a cost-effective manner for the NHS.[17]

For more details on management, see the separate Panic Disorder article.

Prognosis[1]

The condition tends to be long-term, and relapses after treatment are common. There is a better chance of recovery when there are no psychiatric comorbid conditions.

Further reading

- Generalised anxiety disorder; NICE CKS, June 2022 (UK access only)
- Paul T, Varshney A, Singh AP; Effectiveness of Neurofeedback Therapy Adjunct to Cognitive Behavioral Therapy in Agoraphobia: A Case Study. Ann Neurosci. 2022 Oct;29(4):249-254. doi: 10.1177/09727531221145768. Epub 2023 Feb 6.

Authored by:	Peer Reviewed by: Dr Toni Hazell	
Originally Published: 20/11/2023	Next review date: 30/04/2023	Document ID: doc_1565

View this article online at: patient.info/doctor/agoraphobia-pro

Discuss Agoraphobia and find more trusted resources at Patient.