Agoraphobia: clinical features and treatment strategies

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Abstract

This contribution provides definitions of agoraphobia and discusses the relationship between agoraphobia and panic attacks. Information about epidemiology and prognosis is presented, along with current theories concerning aetiology. There is a discussion as to why some panic patients become agoraphobic. A literature review suggests that patients with agoraphobia are more likely to be depressed, have avoidant and dependent personality traits and lower levels of self-esteem and self-sufficiency than patients with panic disorder who are less avoidant. These factors need to be taken into account when planning treatment. The new NICE guidelines for management are provided. In particular, adaptations of panic treatment for more avoidant clients are considered in detail.

Keywords agoraphobia; cognitive therapy; NICE guidelines; panic attacks; vulnerability factors

Definitions

In ICD-10,[1] the term 'agoraphobia' refers to an overlapping cluster of phobias. Feared situations include travelling alone, being in crowds or public places and entering shops. Lack of an immediate exit is a key trigger for anxiety, and many sufferers fear collapsing in public.

In DSM-IV-TR,[2] agoraphobia itself is not a codable disorder but is defined as follows.

- Anxiety about being in places or situations from which escape might be difficult (or embarrassing) or help might not be available in the event of having an unexpected or situationally predisposed panic attack or panic-like symptoms. Agoraphobic fears typically involve characteristic clusters of situations that include: being outside the home alone; being in a crowd or standing in a queue; being on a bridge; and travelling in a bus, train or automobile.
- The situations are avoided (e.g. travel is restricted) or else are endured with marked distress or with anxiety about having a panic attack or panic-like symptoms, or require the presence of a companion.
- The anxiety or phobic avoidance is not better accounted for by another mental disorder.

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The relationship between agoraphobia and panic attacks

In DSM-IV-TR, agoraphobia is defined in relation to the symptoms of panic attacks. Salkovskis and Hackmann have pointed out that there are many reasons for motivated avoidance of the situations feared by agoraphobics, only some of which involve fears of panic attacks or panic-like symptoms.[3] For example, a person with a neurological disorder might be afraid of venturing out alone for fear of not being able to remember how to get home, or for fear of falling over; in this case the fears may be entirely realistic. However, when the fears are centred around panic attacks or limited-symptom attacks, it is hypothesized in the cognitive model of panic that the fears are unrealistic. Indeed, a central element of cognitive therapy is the attempted reduction of the catastrophic misinterpretations of the causes and consequences of bodily sensations, particularly those experienced during periods of autonomic arousal.[4]

The DSM-IV-TR criteria for agoraphobia may have restricted our understanding of the disorder, as they have led some to consider that agoraphobia is a secondary psychological phenomenon and that panic attacks are the principal cause of the disorder. However, this then leads to speculation as to why some patients with panic symptoms become avoidant, while others do not.[5] There is also the observation that many people with severe agoraphobia have never met criteria for panic disorder. Indeed, 50% of agoraphobics in the community have never experienced a panic-like state or panic disorder.[6] However, by definition they must fear panic-like symptoms in situations where escape might be difficult or embarrassing, or where help may not be available. The cognitive model of anxiety disorders suggests that agoraphobic avoidance may be motivated by unrealistic fears of the *consequences* of having panic symptoms in particular situations where the person feels trapped or far from help.

Epidemiology

In studies using DSM-III criteria, the 1-year prevalence of agoraphobia without panic disorder was estimated at 1.7% in men and 3.8% in women, and the lifetime prevalence in both sexes was estimated at between 6% and 10%. It is notable that agoraphobia is much more common in women than men, while panic disorder is more equally distributed between the sexes, though still more common in women.

Aetiology

Theories of agoraphobia need to explain the origin of the panic-type symptoms, and why these symptoms spread and recur persistently in particular agoraphobic situations. The main theories concerning panic symptoms, summarized in Taylor *et al.* (see *PSYCHIATRY* 2007; **6:** 188–92) on the psychopathology of panic disorder are as follows.

The cognitive hypothesis – panic attacks or limited-symptom attacks result from an individual's relatively enduring tendency to catastrophically misinterpret bodily sensations, mainly those accompanying autonomic arousal.[4]

Psychodynamic theories – these highlight developmental traumas.

Biological theories – these highlight neurotransmitter systems and/or neuroanatomical factors.

Some theorists have suggested that agoraphobia represents a later stage of panic disorder, and that agoraphobia is an understandable conditioned response to situations similar to those in which unexpected panic attacks have previously occurred. However, evidence to support this is scant and inconsistent. There are striking differences in the histories of those with panic disorder without avoidance and those with severe agoraphobia. Patients with agoraphobia have an earlier age of onset (contrary to predictions from the disease-stage model) and a history more often characterized by school refusal and other difficulties.

Salkovskis has suggested that the data are consistent with two possibilities: either there are individual differences in the reaction to panic and anxiety, or agoraphobia with panic may represent a more severe variant (rather than a later stage).[7]

Why are some patients with panic symptoms more likely to become agoraphobic?

This question has been studied by a number of investigators.[5,8] It appears that, relative to panic disorder patients with little or no avoidance, those with moderate or severe agoraphobia are more likely to have social evaluative concerns, which may enhance their fears of having panic symptoms or even becoming ill in a public place while under scrutiny from strangers who might be critical or unsupportive. There are also a number of studies suggesting that those with more severe levels of avoidance are those with lower levels of perceived self-efficacy, assertiveness and self-sufficiency; more dependent personality traits and higher levels of depression; and often a history of separation anxiety and school refusal. In short, these individuals appear to lack confidence in their ability to cope with challenging interpersonal situations. In addition, relatives of agoraphobics are more likely to have suffered from school phobia or agoraphobia than the relatives of those with panic disorder with lower levels of avoidance.

Whether these characteristics are inherited or acquired, it seems likely that many people who suffer from agoraphobia have early lives characterized by significant interpersonal fears concerning their own inadequacy and lack of trust in others. Agoraphobic avoidance is greater in women than in men, possibly because of societal stereotypical roles that shape personality, or because gender roles have made it somewhat easier for women to adopt an avoidant lifestyle as a way of coping with anxiety.

All the factors described above need to be taken into account when planning treatment for agoraphobia (Table 1).

Factors associated with agoraphobia

Studies suggest that (relative to patients with panic disorder without agoraphobia) patients with agoraphobia are more likely to present with:

- dependent and avoidant personality traits
- a history of separation anxiety, including school refusal
- low levels of self-sufficiency and self-efficacy
- higher levels of depression
- greater fears of loss of mental control, and fainting
- more social evaluative concerns

Table 1

Prognosis

Transient cases may be seen in general practice, but studies suggest that agoraphobia that persists for more than 1 year changes very little in the next 5 years if untreated. Depression is more common in those with more severe agoraphobic avoidance; indeed, depression in panic disorder predicts later development and/or resurgence of avoidance. There is some evidence that patients with unsatisfactory marriages do less well in treatment. Clearly, agoraphobia may have a substantial effect on families: roles have to be redistributed in response to the patient's difficulties, and the social, occupational and leisure activities of the whole family may be affected.

Management

As of December 2006 the National Institute for Health and Clinical Excellence (NICE) guidelines recommend that the psychological treatment of choice should be cognitive–behaviour therapy (CBT), delivered in primary care settings. Treatment should be delivered by trained and supervised clinicians, adhering closely to empirically grounded treatment protocols like those described below. For most patients, 7–14 hours of treatment, delivered in weekly sessions of 1–2 hours, is recommended. Briefer treatment should comprise about 7 hours of treatment supplemented by homework tasks and self-help materials. In some cases it is suggested that intensive treatment delivered over a shorter period might be beneficial.[9]

As recommended by the NICE guidelines, cognitive therapy has been repeatedly shown to be a highly effective treatment for panic disorder with either no, mild or moderate levels of agoraphobia.[10,11] It has been shown to be as effective as a 12-week programme when delivered in a shorter number of sessions, if accompanied by self-help materials.[12] It has not been as extensively tested on patients with more severe levels of avoidance. Classically, treatment of agoraphobia has involved exposure therapy, where the patient was repeatedly asked to enter frightening situations, until habituation occurred and the fear reduced. Following the development of Clark's cognitive approach to panic disorder[4] an element of exposure therapy was added to cognitive therapy for panic disorder, in more avoidant clients (see Table 2). However, a recent experimental study suggests that it may be most efficacious to offer cognitively delivered exposure sessions, in which, rather than relying on habituation of anxiety following repeated exposure, the therapist encourages the patient to test their anxious beliefs by dropping their safety-seeking behaviours in real-life situations (see below). This seems to greatly enhance the effectiveness of a given amount of *in vivo* exposure.[13]

Adaptation of cognitive therapy for panic for more avoidant patients

While agoraphobia does not have a specific tailored intervention, clinical experience suggests that the components of cognitive