03 - 9.3 Agoraphobia

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9.3 Agoraphobia Agoraphobia refers to a fear of or anxiety regarding places from which escape might be difficult. It can be the most disabling of the phobias because it can significantly interfere with a person’s ability to function in work and social situations outside the home. In the United States, most researchers of panic disorder believe that agoraphobia almost always develops as a complication in patients with panic disorder. That is, the fear of having a panic attack in a public place from which escape would be formidable is thought to cause the agoraphobia. Although agoraphobia often coexists with panic disorder, DSM-5 classifies agoraphobia as a separate condition that may or may not be comorbid with panic disorder. HISTORY The term agoraphobia was coined in 1871 to describe the condition of patients who were afraid to venture alone into public places. The term is derived from the Greek words agora and phobos, meaning “fear of the marketplace.” EPIDEMIOLOGY The lifetime prevalence of agoraphobia is somewhat controversial, varying between 2 to 6 percent across studies. According to the DSM-5, persons older than age 65 years have a 0.4 percent prevalence rate of agoraphobia, but this may be a low estimate. The major factor leading to this wide range of estimates relates to disagreement about the conceptualization of agoraphobia’s relationship to panic disorder. Although studies of agoraphobia in psychiatric settings have reported that at least three fourths of the affected patients have panic disorder as well, studies of agoraphobia in community samples have found that as many as half the patients have agoraphobia without panic disorder. The reasons for these divergent findings are unknown but probably involve differences in ascertainment techniques. In many cases, the onset of agoraphobia follows a traumatic event. DIAGNOSIS AND CLINICAL FEATURES The DSM-5 diagnostic criteria for agoraphobia stipulates marked fear or anxiety about at least one situation from two or more of five situation groups: (1) using public transportation (e.g., bus, train, cars, planes), (2) in an open space (e.g., park, shopping center, parking lot), (3) in an enclosed space (e.g., stores, elevators, theaters), (4) in a crowd or standing in line, or (5) alone outside of the home. The fear or anxiety must be persistent and last at least 6 months (Table 9.3-1). Table 9.3-1 DSM-5 Diagnostic Criteria for Agoraphobia

Patients with agoraphobia rigidly avoid situations in which it would be difficult to obtain help. They prefer to be accompanied by a friend or a family member in busy streets, crowded stores, closed-in spaces (e.g., tunnels, bridges, and elevators), and closed-in vehicles (e.g., subways, buses, and airplanes). Patients may insist that they be accompanied every time they leave the house. The behavior can result in marital

discord, which may be misdiagnosed as the primary problem. Severely affected patients may simply refuse to leave the house. Particularly before a correct diagnosis is made, patients may be

terrified that they are going crazy. Mrs. W was a 33-year-old married woman. She visited an anxiety clinic reporting that she felt like she was having a heart attack whenever she left her home. Her disorder began 8 years earlier while attending a yoga class when she suddenly noticed a dramatic increase in her heartbeat, felt stabbing pains in her chest, and had difficulty breathing. She began sweating and trembling and felt dizzy. She immediately went to the emergency department, where an electrocardiogram was performed. No abnormalities were detected. Over the next few months, Mrs. W experienced similar attacks of 15 to 30 minutes' duration about four times per month. She often sought medical advice after each episode, and each time no physical abnormalities were detected. After experiencing a few of these attacks, Mrs. W became afraid of having an attack away from home and would not leave her home unless absolutely necessary, in which case she needed to have her cell phone or be accompanied by someone. Even so, she avoided crowded places such as malls, movie theaters, and banks, where rapid escape is sometimes blocked. Her symptoms and avoidance dominated her life, although she was aware that they were irrational and excessive. She experienced mild depression and restlessness and had difficulty sleeping. DIFFERENTIAL DIAGNOSIS The differential diagnosis for agoraphobia includes all the medical disorders that can cause anxiety or depression. The psychiatric differential diagnosis includes major depressive disorder, schizophrenia, paranoid personality disorder, avoidance personality disorder, and dependent personality disorder. COURSE AND PROGNOSIS Most cases of agoraphobia are thought to be caused by panic disorder. When the panic disorder is treated, the agoraphobia often improves with time. For rapid and complete reduction of agoraphobia, behavior therapy is sometimes indicated. Agoraphobia without a history of panic disorder is often incapacitating and chronic, and depressive disorders and alcohol dependence often complicate its course. TREATMENT Pharmacotherapy Benzodiazepines. Benzodiazepines have the most rapid onset of action against

panic. Some patients use them as needed when faced with a phobic stimulus. Alprazolam (Xanax) and lorazepam (Ativan) are the most commonly prescribed benzodiazepines. Clonazepam (Klonopin) has also been shown to be effective. The major reservations among clinicians regarding the use of benzodiazepines are the potential for dependence, cognitive impairment, and abuse, particularly with long-term use. However, when used appropriately under medical supervision, benzodiazepines are efficacious and generally well tolerated. The most common side effects are mild dizziness and sedation, both of which are generally attenuated by time or change of dose. Caution must be exercised when using heavy or dangerous machinery or when driving, especially when first starting the medication or when the dose is changed. Benzodiazepines should not be used in combination with alcohol because they can intensify its effects. Benzodiazepines are also best avoided in individuals with histories of alcohol or substance abuse unless there are compelling reasons, such as failure to respond to other classes of medications. Selective Serotonin Reuptake Inhibitors. SSRIs have been shown to help reduce or prevent relapse from various forms of anxiety, including agoraphobia. Effective doses are essentially the same as for the treatment of depression, although it is customary to start with lower initial doses than in depression to minimize an initial anxiolytic effect, which is almost always short lived, and to titrate upward somewhat slower toward a therapeutic dose. The main advantages of SSRIs antidepressants include their improved safety profile in overdose and more tolerable side-effect burden. Common side effects of most SSRIs are sleep disturbance, drowsiness, lightheadedness, nausea, and diarrhea; many of these adverse effects improve with continued use. Another commonly reported side effect of SSRIs is sexual dysfunction (i.e., decreased libido, delayed ejaculation in men, delayed orgasm in women), which

rarely improves with time or switching among SSRIs (or from an SSRI to a serotonin-norepinephrine reuptake inhibitor [SNRI]). Proposed strategies to combat sexual dysfunction in patients taking SSRIs include adjunctive use of yohimbine (Yocon), bupropion (Wellbutrin), or mirtazapine (Remeron); dose reduction; or adjunctive use of sildenafil (Viagra). Another issue to be considered when prescribing an SSRI is the possibility of a discontinuation syndrome if these medications are stopped abruptly. Commonly reported symptoms of this condition, which tend to occur 2 to 4 days after medication cessation, include increased anxiety, irritability, tearfulness, dizziness or lightheadedness, malaise, sleep disturbance, and concentration difficulties. This discontinuation syndrome is most common among SSRIs with shorter half-lives (e.g., paroxetine [Paxil]). Tricyclic and Tetracyclic Drugs. Although SSRIs are considered the first-line agents for treatment of panic disorders with or without agoraphobia, the tricyclic drugs clomipramine (Anafranil) and imipramine (Tofranil) are the most effective in the treatment of these disorders. Dosages must be titrated slowly upward to avoid overstimulation (e.g., “jitteriness” syndrome), and the full clinical benefit requires full dosages and may not be achieved for 8 to 12 weeks. Therapeutic drug monitoring

(TDM) may be useful to ensure that the patient is on an adequate dose of medication while avoiding issues of toxicity. The other adverse effects to these antidepressants are related to their effects on seizure threshold, as well as anticholinergic and potentially harmful cardiac effects, particularly in overdose. Psychotherapy Supportive Psychotherapy. Supportive psychotherapy involves the use of psychodynamic concepts and a therapeutic alliance to promote adaptive coping. Adaptive defenses are encouraged and strengthened, and maladaptive ones are discouraged. The therapist assists in reality testing and may offer advice regarding behavior. Insight-Oriented Psychotherapy. In insight-oriented psychotherapy, the goal is to increase the patient’s development of insight into psychological conflicts that, if unresolved, can manifest as symptomatic behavior. Behavior Therapy. In behavior therapy, the basic assumption is that change can occur without the development of psychological insight into underlying causes. Techniques include positive and negative reinforcement, systematic desensitization, flooding, implosion, graded exposure, response prevention, stop thought, relaxation techniques, panic control therapy, self-monitoring, and hypnosis. Cognitive Therapy. This is based on the premise that maladaptive behavior is secondary to distortions in how people perceive themselves and in how other perceive them. Treatment is short term and interactive, with assigned homework and tasks to be performed between sessions that focus on correcting distorted assumptions and cognitions. The emphasis is on confronting and examining situations that elicit interpersonal anxiety and associated mild depression. Virtual Therapy. Computer programs have been developed that allow patients to see themselves as avatars who are then placed in open or crowded spaces (e.g., a supermarket). As they identify with the avatars in repeated computer sessions, they are able to master their anxiety through deconditioning. REFERENCES Chambless DL, Sharpless BA, Rodriguez D, McCarthy KS, Milrod BL, Khalsa SR, Barber JP. Psychometric properties of the mobility inventory for agoraphobia: Convergent, discriminant, and criterion-related validity. Behav Therapy. 2011;42:689. Croft A, Hackmann A. Agoraphobia: An outreach treatment programme. Behav Cogn Psychother. 2013;41:359. Huppert JD, Kivity Y, Barlow DH, Gorman JM, Shear MK, Woods SW. Therapist effects and the outcome–alliance correlation in cognitive behavioral therapy for panic disorder with agoraphobia. Behav Res Ther. 2014;52:26–34. McCabe RE, Gifford S. Psychological treatment of panic disorder and agoraphobia. In: Anthony MM, Stein MB, eds. Oxford

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