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Behaviour Research and Therapy 43 (2005) 1219–1229

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## Diagnosing agoraphobia in the context of panic disorder: examining the effect of DSM-IV criteria on diagnostic decision-making

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Received 24 February 2004; received in revised form 8 July 2004; accepted 23 September 2004

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### Abstract

A diagnostic and statistical manual (DSM)-IV diagnosis of agoraphobia in the context of panic disorder (PD) is based on three nosologically sufficient criteria: (1) avoidance, (2) use of companions, and (3) endurance of situations despite distress. Therefore, an agoraphobia diagnosis can be made across an extremely broad range of cases including when there are no avoidance behaviors (e.g., the patient endures the situation). It was hypothesized that clinicians do not weight these criteria equally and that the DSMs individual, sufficient criteria lead to poor inter-rater reliability. Clinicians ( $N = 48$ ) rated hypothetical patients with symptom profiles emphasizing each of these three criteria. Consistent with expectation, clinicians differentially weighted these criteria. Avoidance was relatively more apt to produce a diagnosis when only one criterion was emphasized in clinical vignettes. Inter-rater reliability was poor in instances when only one sufficient criterion was highlighted. Knowledge concerning DSM criteria resulted in a greater rate of agoraphobia endorsement, but knowledge did not account for the overall pattern of findings. © 2004 Elsevier Ltd. All rights reserved.

*Keywords:* Agoraphobia; Panic disorder; Diagnosis; Reliability; Decision making

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## 1. Introduction

The classification of agoraphobia within the diagnostic and statistical manual for mental disorders (DSM) has undergone significant changes over time and continues to be a controversial issue (Cerny, Himadi, & Barlow, 1984). In particular, the DSM has substantially changed its description of the relationship between panic disorder (PD) and agoraphobia. Marks (1970) originally suggested that agoraphobia was a phobic disorder arising from fears of public places that may or may not occur with panic attacks. Consistent with Marks' (1970) contentions, the DSM-III (American Psychiatric Association (APA), 1980) classified agoraphobia as a phobic disorder that could occur with or without panic attacks whereas PD was considered to be a separate class of anxiety disorders called anxiety states or anxiety neuroses. Moreover, agoraphobia received primary consideration since PD could not be diagnosed if the patient met criteria for agoraphobia. Over time, as researchers increasingly recognized that agoraphobia is often a consequence of experiencing panic attacks, the DSM has reversed the relationship between these conditions such that in the DSM-III-R (American Psychiatric Association (APA), 1987) and DSM-IV (American Psychiatric Association (APA), 1994), agoraphobia is typically considered secondary to PD. In fact, in the DSM-IV, agoraphobia is only coded in the context of either PD or limited-symptom panic attacks (agoraphobia without history of PD). Thus, agoraphobic behaviors are now more commonly conceptualized as panic-related sequelae (Frances et al., 1993; Goldstein & Chambless, 1978). Technically, Agoraphobia without a History of PD can also be diagnosed in the context of concerns regarding incapacitation due to a medical condition or fear of embarrassment because of unpredictable medical symptoms. In this report, we are specifically dealing with making an agoraphobia diagnosis in the context of panic.

In more recent iterations of the DSM, there has also been some modification of the diagnostic specification of agoraphobia. In the DSM-III-R (American Psychiatric Association (APA), 1987), an agoraphobia diagnosis is indicated when the person is so fearful of having a panic attack that they restrict travel (avoidance), need a companion to travel with them (use of companions), or endure agoraphobic situations despite intense anxiety (distress). Of note, according to the definition offered in the DSM-III-R, agoraphobia is not technically restricted to individuals exhibiting avoidance behavior; these individuals might be able to travel extensively but need a companion to do so, or they might even be able to travel alone while experiencing significant distress. The broad scope of these three sufficient criteria has been criticized as being overinclusive (Cox, Endler, & Swinson, 1995). However, the DSM-III-R provides some clarification about the assessment of agoraphobia in the form of a severity specifier highlighting avoidance behavior. In the specifier, patients are rated as mild, moderate, or severe (or in a state of remission). In each instance, avoidance is the central issue to be considered. For example, a mild specifier is given when there is some avoidance or endurance with distress, and when the patient is able to travel alone when necessary. The moderate specifier is given when avoidance results in significant lifestyle changes, such as being able to travel unaccompanied only a few miles from home. The severe specifier is indicated when the person is nearly housebound or can only leave the home if he or she is accompanied.

In the DSM-IV (American Psychiatric Association (APA), 1994), the criteria for making an agoraphobia diagnosis in the context of PD are relatively unchanged with one important exception. In the DSM-IV, there are no longer severity specifiers for agoraphobia. The omission

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