Published in final edited form as:

Depress Anxiety. 2015 July ; 32(7): 502–508. doi:10.1002/da.22361.

Clinical consequences of the revised DSM-5 definition of agoraphobia in treatment-seeking anxious youth

Danielle Cornacchio, B.S.¹, Tommy Chou, M.A.¹, Hayley Sacks, B.S.², Donna Pincus, Ph.D.³, and Jonathan Comer, Ph.D.¹

¹Department of Psychology, Mental Health Interventions and Technology (MINT) Program, Florida International University, Miami, FL

²Weill Cornell College of Medicine, New York, NY

³Department of Psychology, Center for Anxiety and Related Disorders (CARD), Boston University, Boston, MA

Abstract

Background—In DSM-5, the agoraphobia core symptom criterion has been revised to require fear about multiple situations from across at least two distinct domains in which escape might be difficult or panic-like symptoms might develop. The present study examined patterns and correlates of the recent change in a sample of anxious youth with symptom presentations consistent with the DSM-IV agoraphobia definition and/or specific phobia (SP) to consider how the recent diagnostic change impacts the prevalence and composition of agoraphobia in children and adolescents.

Method—Analyses (N=151) evaluated impairment and correlates of agoraphobic youth who no longer meet the DSM-5 agoraphobia criteria relative to agoraphobic youth who do meet the new DSM-5 criteria. Secondary analyses compared agoraphobic youth not meeting DSM-5 criteria to SP youth.

Results—One-quarter of youth with symptom presentations consistent with the DSM-IV agoraphobia definition no longer met criteria for DSM-5 agoraphobia, but showed comparable severity and impairment across most domains to youth who do meet criteria for DSM-5 agoraphobia. Further, these youth showed higher levels of anxiety sensitivity and internalizing psychopathology relative to youth with SP.

Conclusions—A substantial proportion of impaired youth with considerable agoraphobic symptom presentations have been left without a specified anxiety diagnosis by the DSM-5, which may affect their ability to receive and/or get coverage for services and their representation in treatment evaluations. Future DSM iterations may do well to include a “circumscribed” agoraphobia specifier that would characterize presentations of fear or anxiety about multiple situations, but that do not span across at least two distinct situational domains.

Correspondence: Jonathan S. Comer, PhD, Center for Children and Families, Mental Health Interventions and Technology (MINT) Program, Department of Psychology, Florida International University, 11200 S.W. 8th Street, Miami, FL 33199 (telephone: 305.348.7580; fax: 305.348.3646; jocomer@fiu.edu).

Financial disclosures: No authors have financial interests to declare.

Keywords

agoraphobia; child/adolescent; anxiety; assessment; diagnosis; phobias

Agoraphobia—characterized by fear or anxiety about multiple situations in which escape might be difficult or panic-like symptoms might develop—can onset in childhood and has a lifetime prevalence rate of 2.5%–6.7%.^{1–6} Left untreated, agoraphobia is associated with decreased well-being and daily functioning and is correlated with other serious forms of psychopathology, such as depression, substance misuse, and suicidality.^{1–2,7–8} Given that earlier onset of psychopathology is associated with more intractable symptomology and impairment across the lifespan,⁹ early treatment for youth-onset agoraphobia is critical.

Accurate assessment is the first step of effective intervention and must occur within the context of a valid and reliable system of classification. There has been much debate as to whether various iterations of the *Diagnostic and Statistical Manual (DSM)* have offered optimal definitions with which to diagnose agoraphobia,^{10–13} and the nosology of agoraphobia has been in flux across DSM iterations. From DSM-III through DSM-IV-TR, agoraphobia was not an independent codable disorder, but rather a sequela or variant of the panic disorder (PD) spectrum—i.e., individuals were diagnosed as having PD with or without agoraphobia.¹² Importantly, Wittchen and colleagues⁵ examined the prevalence, symptoms, stability of, and relationships among, panic attacks, PD, and agoraphobia; some of their findings suggest that temporally primary PD revealed only a moderate risk for subsequent agoraphobia, and primary agoraphobia revealed only a moderate risk for subsequent PD. Additionally, they found differences in incidence, symptom patterns, and stability, between PD and agoraphobia. They concluded that, as in the International Classification of Diseases 10th edition,¹⁴ agoraphobia should be classified as an independent disorder category. Recently, Wittchen and colleagues¹¹ formally recommended that agoraphobia no longer be conceptualized in DSM as a subordinate or residual form of PD, and indeed in the DSM-5 agoraphobia has now been decoupled from PD and stands as an independent codable category.

This substantial shift has been accompanied by a revised operationalization of the core agoraphobia symptom criterion of fear or anxiety about multiple situations in which escape might be difficult or panic-like symptoms might develop. Specifically, whereas DSM-IV-TR did not specify the number or nature of feared and avoided situations for diagnosis, Criterion A of the agoraphobia definition was tightened in DSM-5 to now require fear/anxiety about *at least two* of the following five pre-specified and distinct situational domains: public transportation, being in open spaces, being in enclosed places, standing in line or being in a crowd, and being outside of the home. Although DSM-IV did require fear or anxiety about multiple situations, it did not require these situations fall across multiple predetermined and distinct situational domains.

The more stringent DSM-5 Criterion A of the agoraphobia definition could mean that some youth who would have met DSM-IV agoraphobia criteria will not receive a DSM-5 agoraphobia diagnosis. For example, an adolescent with highly impairing and debilitating anxiety about being in theaters, cinemas, auditoriums, and elevators because escape might be

difficult would no longer meet criteria for agoraphobia because the avoided situations triggering fear all fall under the same *single* domain: “being in enclosed places.” It remains unclear whether the hypothetical adolescent with this symptom presentation meaningfully differs from another hypothetical adolescent who experiences intense and debilitating fear about being in theaters and parking lots and whose associated avoidance also causes impairment. Unlike the first adolescent, this latter adolescent would meet DSM-5 agoraphobia criteria because the feared and avoided situations span across *multiple* DSM-5 pre-specified situational domains (i.e., Domains 2 *and* 3; enclosed places *and* open spaces).

A definition change that reduces the number of diagnosed cases is not inherently cause for concern. It could be that individuals not meeting DSM-5’s more stringent Criterion A show reduced severity or experience less distress and functional impairment relative to individuals who do meet all of DSM-5 agoraphobia criteria. Accordingly, their exclusion from the revised agoraphobia diagnosis is not problematic. Additionally, a failure to experience marked fear across at least two of the five DSM-5 pre-specified situational domains might indicate that an alternate diagnostic category more appropriately captures a child’s symptom presentation. For example, fear and avoidance within only one pre-specified Criterion A situational domain may be better conceptualized as a specific phobia (SP). The symptom presentation of an adolescent who has severely impairing and debilitating anxiety about being in theaters, cinemas, auditoriums, and elevators because escape might be difficult might be better captured by a diagnosis of SP of enclosed places than an agoraphobia diagnosis. In fact, there is evidence of strong relationships between agoraphobia and SP, especially with regard to the situational and natural environment SP subtypes.^{15–16} While research does document that SP can be a severely impairing disorder⁴, some have cautioned against the use of SP to characterize more circumscribed agoraphobia, cautioning that SP can have a lower perceived clinical severity compared to other anxiety disorders and thus may inadequately portray the magnitude of associated agoraphobic avoidance.¹⁷ Finally, it could be argued that only an insignificant proportion of DSM-IV agoraphobia cases no longer meet the more stringent DSM-5 definition, and that the better specified DSM-5 Criterion A will improve inter-rater reliability without sacrificing accurate assessment for a meaningful proportion of individuals.

At present, the impact that the revised DSM-5 agoraphobia definition will have on the identification of agoraphobic youth presenting for treatment remains unclear. To date, research has not evaluated the proportion of anxious youth who met the DSM-IV agoraphobia definition but no longer meet the DSM-5 definition, nor has work examined whether these agoraphobic youth no longer meeting criteria for agoraphobia differ in meaningful ways in terms of severity and clinical correlates. The present study examined the impact of the revised DSM-5 agoraphobia definition on the prevalence and clinical correlates of agoraphobic youth in a large outpatient sample of treatment-seeking anxious youth. Specifically, we evaluated: (1) the proportion of youth who met criteria for DSM-IV agoraphobia who no longer meet DSM-5’s Criterion A; (2) whether these agoraphobic youth no longer meeting DSM-5’s Criterion A show any lower severity or impairment than agoraphobic youth qualifying for DSM-5 agoraphobia diagnosis; (3) the proportion of agoraphobic youth no longer meeting DSM-5 agoraphobia criteria who also do not meet criteria for *any* other DSM anxiety diagnoses; and (4) the extent to which agoraphobic youth

no longer meeting DSM-5's Criterion A show comparable levels of severity, impairment, and agoraphobic avoidance to youth with SP (which would suggest SP might accurately characterize such cases).

Method

Participants

Participants were children and their parents seeking services at a university-based outpatient clinic specializing in anxiety disorders in a New England urban region between 2004–2013. Across this time, of the 688 presenting youth who met diagnostic criteria for a DSM-IV-TR anxiety disorder, 12.1% (N=83) met the DSM-IV definition of agoraphobia (albeit agoraphobia was not an independently codable disorder in DSM-IV) and were included in the present analyses. Secondary analyses compared DSM-IV agoraphobic youth no longer meeting DSM-5 agoraphobia criteria to youth with a principal/co-principal SP diagnosis and no concurrent PD or agoraphobia diagnosis (N=68). Across the 151 youth, youth ranged in age from 6–18 years (M=12.7 SD=3.12); 60.9% were female and 83.4% were non-Hispanic White/Caucasian). Families ranged in resources: 19.6% were $\leq 300\%$ of the national poverty line for their year of assessment (e.g., in 2007 \$63,609 for a family of four) whereas 11.3% of household earned at least 600% of the national poverty line. Table 1 presents further sociodemographic information broken down across agoraphobic youth who did and did not meet DSM-5 agoraphobia Criterion A, as well as youth with SP.

Youth across the full sample met criteria for other comorbid DSM-IV disorders, including generalized anxiety disorder (19.9%), panic disorder with agoraphobia (43.7%), social anxiety disorder (15.9%), agoraphobia without a history of panic disorder (11.3%), separation anxiety disorder (7.9%), anxiety disorder not otherwise specified (6.6%), attention-deficit hyperactivity disorder (6.6%), obsessive-compulsive disorder (2.6%), major depressive disorder (5.3%), dysthymia (4.6%), enuresis (2.6%), oppositional defiant disorder (2.6%), selective mutism (1.8%), panic disorder without agoraphobia (1.3%), post-traumatic stress disorder (1.3%), depression not otherwise specified (0.7%), and disruptive behavior disorder not otherwise specified (0.7%).

Measures

Child diagnoses—*The Anxiety Disorders Interview Schedule, Child and Parent Version* (ADIS-IV-C/P)¹⁸ is a semi-structured diagnostic interview administered to parents and children to assess internalizing and externalizing problems according to DSM-IV-TR criteria. DSM-IV diagnoses were determined using child and parent reports; parent and child diagnostic profiles are integrated into a composite diagnostic profile using the “or rule.”¹⁹ Diagnoses are assigned a clinical severity rating (CSR), ranging from 0 (no symptoms) to 8 (extremely severe symptoms); CSR ≥ 4 indicates that diagnostic criteria for the particular disorder has been met and CSR ≤ 3 indicates subthreshold diagnostic presentation. The ADIS-C/P is the most widely used interview for the assessment of child anxiety disorders and has demonstrated strong reliability, validity, and sensitivity to change.^{20–21}

The ADIS-C/P was also used to determine whether youth met the revised Criterion A of the DSM-5 agoraphobia definition via examination of the agoraphobic situations checklist of the ADIS-C/P agoraphobia module. Drawing on the specific examples provided in the DSM-5 agoraphobia definition for each of the five agoraphobic situation domains, the following fear items were used to define Criterion A: Domain 1=school bus, riding in a car, public transportation; Domain 2=open spaces; Domain 3=theater/auditorium, enclosed places; Domain 4=crowds, waiting in line; Domain 5=being away from home. Items on the agoraphobic situations checklist for which the parent or child reported a fear rating of 4 or greater were considered endorsed. A given domain was considered feared/avoided if at least one item from that domain was endorsed. DSM-5 agoraphobia Criterion A was considered met when 2 domains were feared/avoided.

Child internalizing psychopathology and social functioning—*The Child Behavior Checklist (CBCL)*²² is a well-supported parent-report of behavioral and emotional problems in children 6–18.²² Parents rate each of 120 items from 0 (*not true*) to 2 (*very true or often true*) about their child across the past 6 months. T-scores for each subscale reflect age- and gender-matched norms. The Total Internalizing and Social Functioning T-scores were used in the present data analyses.

Child anxiety severity—*The Multidimensional Anxiety Scale for Children (MASC)*²³ is a 39-item self-report measure administered to children to assess symptoms of anxiety. MASC subscales assess somatic symptoms, harm avoidance, social anxiety, and separation anxiety and has demonstrated solid psychometric properties across multiple samples ($\alpha=.88$ in present sample).^{21, 23–25}

Child depression symptoms—*The Children's Depression Inventory (CDI)*²⁶ is a 27-item self-report rating scale assessing depressive symptomatology in children. The CDI has been supported as a continuous measure of depressive symptomatology among anxious youth,²⁷ and has demonstrated excellent internal consistency in both clinical and nonclinical samples ($\alpha>.80$; $\alpha=.90$ in present sample)^{28–30} and acceptable test-retest reliability in both clinical and nonclinical samples.^{26,28,31–33}

Child anxiety sensitivity—*The Childhood Anxiety Sensitivity Index (CASI)*³⁴ is an 18-item self-report questionnaire measuring anxiety sensitivity, which refers to the fear of anxiety and the fear that anxiety-related symptoms may have harmful social and physical consequences. The CASI asks children and adolescents to indicate how well a statement describes them (e.g., “When I notice that my heart is beating fast, I worry there might be something wrong with me”) on a scale from 1 (*not at all*) to 3 (*a lot*). This measure has demonstrated good reliability ($\alpha=.87$; $\alpha=.98$ in present sample) and test-retest reliability ($r=.82$).^{34,35}

Agoraphobic avoidance—An agoraphobic avoidance score was computed to capture the pervasiveness of youths' avoidance of various situations due to fears that escape might be difficult or that panic-like symptoms might develop. Specifically, we tallied the number of situations endorsed in the agoraphobic situation checklist of the ADIS-C/P as being avoided due to fears that escape in these situations might be difficult or that panic-like symptoms

might develop. The ADIS-IV-C/P agoraphobia module has demonstrated strong psychometric properties.²⁰ Situations were considered avoided if either the child or parents endorsed a situation as being avoided due to fears that escape might be difficult or that panic-like symptoms might develop. Internal consistency was strong in the present sample ($\alpha = .91$).

Procedure

Participants were recruited from the flow of families seeking anxiety services at a New England outpatient clinic for anxiety and related disorders. Families first completed a standardized phone screen as part of clinic procedures; youth were excluded who had any of the following: current psychotic symptoms, suicidal or homicidal risk, >1 hospitalization for severe psychopathology within previous 5 years, or moderate to severe intellectual impairments. To participate, youth on psychotropic medications were required to be stabilized on their current dosage for >1 month. After obtaining informed consent, a diagnostician administered parent and child ADIS interviews separately, and used the “or rule”¹⁹ to integrate diagnostic profiles to generate a composite diagnostic profile for each child. Youth then completed the MASC, CDI, and CASI, and mothers completed the CBCL. Assessment material was presented and reviewed at a weekly diagnostician meeting in which child and parent diagnostic profiles were reviewed to arrive at consensus CSRs approved by the full diagnostic team. Diagnosticians were 22 clinical psychologists, postdoctoral associates, and doctoral candidates specializing in the assessment and treatment of childhood anxiety disorders. All diagnosticians met internal reliability criteria (observing 3 completed interviews, collaboratively administering 3 interviews with a trained diagnostician, and conducting supervised interviews until achieving full diagnostic profile agreement on 3 of 5 consecutive supervised assessments).

Data Analysis

Youth diagnosed with DSM-IV agoraphobia were grouped into: (a) those meeting Criterion A of the revised DSM-5 agoraphobia definition, and (b) those *not* meeting Criterion A of the revised definition. Rates of the two groups among youth with presentations consistent with DSM-IV agoraphobia were computed. Among agoraphobic youth who did not meet DSM-5 Criterion A, percentages were computed to reveal the proportions of such individuals who did not meet criteria for any other non-PD anxiety disorder diagnosis, as well as individuals who did not meet criteria for *any* other anxiety diagnosis. Chi-square analyses and ANOVA's were used to determine whether the three groups differed on age, gender, and race. ANCOVAs examined differences in clinical severity, total anxiety, somatic symptoms, number of avoided situations (agoraphobic avoidance), anxiety sensitivity, internalizing psychopathology, depressive symptoms, and social functioning among agoraphobic youth who did meet DSM-5 Criterion A, agoraphobic youth who did not meet DSM-5 Criterion A, and youth with a diagnosis of SP, controlling for number of diagnoses and age.

Results

Preliminary Findings

Table 1 displays the sociodemographic composition associated with agoraphobic youth who did and did not meet DSM-5 agoraphobia Criterion A as well as SP youth. Chi-square analyses examining whether the groups differed on race and gender showed no significant group differences. An ANOVA examining age showed that youth meeting for DSM-IV agoraphobia were significantly older than the SP group. Subsequent analyses controlled for age.

Prevalence and comorbidity patterns of agoraphobic youth who do not meet DSM-5 agoraphobia Criterion A

Among youth with symptom presentations consistent with the DSM-IV definition of agoraphobia ($N=83$), 24% ($N=20$) did not meet the more stringent Criterion A of the DSM-5 agoraphobia definition. Among those not meeting DSM-5 agoraphobia Criterion A, 40% were not assigned any other non-PD DSM-IV diagnosis; 25% of those youth were not assigned *any* other specified anxiety disorder (including PD), although technically could be assigned “other specified anxiety disorder.” The groups did not differ on number of total diagnoses, $F(2,148)=1.54$, $p=.217$.

Clinical dimensions across groups

Table 2 presents clinical characteristics of youth with symptom presentations consistent with DSM-IV agoraphobia, broken down by youth who do and do not meet the revised DSM-5 agoraphobia Criterion A, as well as youth who meet criteria for SP. Agoraphobic youth no longer classified under the DSM-5 agoraphobia criteria showed moderate-to-severe clinical severity of their principal diagnosis ($M_{CSR}=5.70$, $SD=1$), considerable total anxiety problems, somatic complaints, agoraphobic avoidance, anxiety sensitivity, internalizing psychopathology, depressive symptoms, and reduced social functioning. A series of ANCOVAs examined principal diagnosis CSR, total anxiety, somatic complaints, number of avoided situations (agoraphobic avoidance), anxiety sensitivity, internalizing psychopathology, depressive symptoms, and social functioning among the three groups controlling for number of diagnoses and age. Relative to agoraphobic youth meeting DSM-5 Criterion A, agoraphobic youth not meeting the revised DSM-5 Criterion A showed comparable clinical severity, anxiety problems, somatic complaints, anxiety sensitivity, internalizing psychopathology, depressive symptoms, and social functioning, and showed somewhat lower levels of agoraphobic avoidance. Relative to SP youth, agoraphobic youth not meeting the revised DSM-5 criterion A showed higher levels of anxiety sensitivity, and internalizing psychopathology. Relative to youth who meet both DSM-IV and DSM-5 agoraphobia criteria, SP youth showed lower clinical severity, somatic complaints, agoraphobic avoidance, anxiety sensitivity, and internalizing psychopathology..

Discussion

DSM-5 brings a substantial shift in the definition of agoraphobia. Specifically, the disorder is no longer defined as simply a subordinate/variant of PD, and in response to concerns

about previously poor specification of what constitutes multiple agoraphobic “situations,”¹¹ the core symptom criterion has now been revised to require fear or anxiety about multiple situations *from across at least two pre-specified and distinct domains* in which escape might be difficult or panic-like symptoms might develop. The present findings suggest that although the more specified DSM-5 agoraphobia definition may improve diagnostic reliability, the new Criterion A may be misguided with regard to youth. Specifically, in the present treatment-seeking sample, roughly one in four youth with symptom presentations consistent with DSM-IV agoraphobia do not meet Criterion A of the DSM-5 agoraphobia definition, and importantly these youth show comparable levels of comorbidity, clinical severity, anxiety symptoms, somatic complaints, anxiety sensitivity, internalizing psychopathology, depressive symptoms, and social functioning relative to youth who do meet DSM-5 agoraphobia Criterion A. Although agoraphobic avoidance (the number of avoided situations) was somewhat lower among the agoraphobic youth not meeting DSM-5 definition relative to those with DSM-5 agoraphobia, a considerable proportion of these “undiagnosed” agoraphobic youth were not diagnosed with any other non-PDA specified anxiety diagnoses, suggesting such impaired youth are now without a specified anxiety disorder for classifying their anxiety and related symptoms (although a diagnosis of “other specified anxiety disorder” can be applied).

In the context of DSM-5, these agoraphobic youth who do not meet Criterion A can be classified as having either: (a) SP, or (b) other specified anxiety disorder. However, present analyses found these youth present with greater anxiety sensitivity and internalizing psychopathology than youth with SP, suggesting that diagnosing such youth with SP may be misguided. This finding is consistent with LeBeau and colleagues¹⁷ cautions against the use of SP to characterize more circumscribed agoraphobia. Although considerable epidemiologic research documents how impairing SP can be^{4,36} LeBeau and colleagues¹⁷ exemplify that SP can have a low perceived clinical severity compared to other anxiety disorders, which could inaccurately convey the magnitude of symptoms in agoraphobia-affected individuals. Further, anxiety sensitivity is a set of symptoms particularly salient in agoraphobia and PD, and supported treatments for agoraphobia and PD specifically target anxiety sensitivity symptoms, whereas treatment for SP does not specifically target anxiety sensitivity.

Moreover, diagnosing such children with DSM-5 “other specified anxiety disorder” (DSM-5’s revised ‘anxiety disorder not otherwise specified’ category) is problematic on several fronts. First, diagnostic labels act as shorthands to succinctly convey key information to other providers, payers, and review panels evaluating quality of care. Supported treatments across the anxiety disorders differ from one another in important ways, including whether or not there is strong support for SSRIs, which SSRIs are most supported for which anxiety disorders, and what the specific focus of cognitive-behavioral therapy should entail.^{37–39} A diagnosis of “other specified anxiety disorder” does little to communicate information suggesting an indicated course of treatment. Second, clinical trials for child anxiety typically require a DSM-specified diagnosis for study inclusion, and as such, the current agoraphobia definition may interfere with the evaluation of treatment methods for youth with circumscribed agoraphobia failing to meet DSM-5 Criterion A but who nonetheless present with comparable clinical severity as youth meeting full criteria for

DSM-5 agoraphobia. Third, many third party payers require DSM-specified diagnoses for reimbursement, and services for a diagnosis of “other specified anxiety disorder” may not be universally covered.

Several agoraphobic youth failing to meet DSM-5 criteria did still meet PD criteria. However, the PD definition does little to capture agoraphobic avoidance, and recent evidence suggests that even when individuals are considered full responders to PD treatment, unsuccessfully managed agoraphobic avoidance at post-treatment is associated with earlier and higher relapse rates,⁴⁰ underscoring the value of diagnostic documentation of agoraphobic symptoms in clinical profiles even when a PD diagnosis is already assigned. Treatments targeting only PD symptoms may target interoceptive symptoms but may fail to adequately attend to the situational avoidance at the heart of agoraphobia problems.

Although the present study examined a relatively large and well-defined clinic-based sample of diagnosed youth, several limitations warrant comment. First, we focused on youth below age 18, but many agoraphobia cases onset in young adulthood and beyond.² Similar work with affected adults is needed in order to inform the extent to which the revised agoraphobia definition may be problematic across the lifespan. Second, this study was conducted in a university-based, urban outpatient clinic specializing in anxiety disorders. Findings may not be representative of youth presenting to other settings, populations of youth with differing sociodemographic make-ups, or the general population of youth. Third, some participants were being managed on stabilized psychotropic medications, which could have affected observed symptom presentations. Finally, the ADIS-IV-C/P was developed for correspondence with DSM-IV, and it is possible that some examples of agoraphobia situational domains specified in the DSM-5 agoraphobia definition were not adequately assessed.

Despite these limitations, the present analysis offers an important data-based portrait of the impact of the revised DSM-5 agoraphobia definition on youth presenting for outpatient services. Roughly one quarter of treatment-seeking youth with presentations consistent with the DSM-IV agoraphobia do not meet DSM-5 criteria for agoraphobia, and there is little evidence that these youth have meaningfully less severe or interfering presentations. Importantly, one of the promising developments of the DSM-5 is its intended release as more of a “living” document than previous DSM iterations—one that can be updated regularly using new technologies to respond to incremental progress and research breakthroughs with more speed and agility than previously possible. This format can presumably shorten the gap between research advances and their reflection in the diagnostic nomenclature. The present analysis suggests that future iterations of the DSM-5 agoraphobia definition may do well to reconsider the current criterion A, or may do well to include a “circumscribed” agoraphobia specifier that would characterize presentations of fear or anxiety about multiple situations in which escape might be difficult or panic-like symptoms might develop, but may nonetheless fail to span across at least two pre-specified and distinct situational domains.

Acknowledgments

Funding: This work was supported by the NIH (K23 MH090247, R01 MH068277).

References

1. Grant BF, Hasin DS, Stinson FS, et al. The epidemiology of DSM-IV panic disorder and agoraphobia in the united states: Results from the national epidemiologic survey on alcohol and related conditions. *J Clin Psychiatry*. 2006; 67(3):363–374. DOI: 10.4088/JCP.v67n0305 [PubMed: 16649821]
2. Kessler RC, Avenevoli S, Costello EJ, et al. Prevalence, persistence, and sociodemographic correlates of DSM-IV disorders in the national comorbidity survey replication adolescent supplement. *Arch Gen Psychiatry*. 2012; 69(4):372–380. DOI: 10.1001/archgenpsychiatry.2011.160 [PubMed: 22147808]
3. Kessler RC, Petukhova M, Sampson NA, Zaslavsky AM, Wittchen H. Twelve-month and lifetime prevalence and lifetime morbid risk of anxiety and mood disorders in the United States. *Int J Meth Psych Res*. 2012; 21(3):169–184. DOI: 10.1002/mpr.1359
4. Magee WJ, Eaton WW, Wittchen H, McGonagle KA, Kessler RC. Agoraphobia, simple phobia, and social phobia in the national comorbidity survey. *Arch Gen Psychiatry*. 2012; 53(2):159–168. DOI: 10.1001/archpsyc.1996.01830020077009
5. Wittchen HU, Nocon A, Beesdo K, et al. Agoraphobia and panic. Prospective-longitudinal relations suggest a rethinking of diagnostic concepts. *Psychother Psychosom*. 2008; 77(3):147–157. DOI: 10.1159/000116608 [PubMed: 18277061]
6. Wittchen H, Reed V, Kessler RC. The relationship of agoraphobia and panic in a community sample of adolescents and young adults. *Arch Gen Psychiatry*. 1998; 55(11):1017–1024. DOI: 10.1001/archpsyc.55.11.1017 [PubMed: 9819071]
7. Fifer SK, Mathias SD, Patrick DL, Mazonson PD, Lubeck DP, Buesching DP. Untreated anxiety among adult primary care patients in a health maintenance organization. *Arch Gen Psychiatry*. 1994; 51(9):740–750. DOI: 10.1001/archpsyc.1994.03950090072010 [PubMed: 8080351]
8. Keller MB, Hanks DL. Course and outcome in panic disorder. *Prog Neuropsychopharmacol Biol Psychiatry*. 1993; 17(4):551–570. DOI: 10.1016/0278-5846(93)90005-D [PubMed: 8362071]
9. Cicchetti, D. Development and psychopathology. In: Cicchetti, D., Cohen, D., editors. *Developmental psychopathology, Vol 1: Theory and method*. 2. Hoboken, NJ: John Wiley & Sons Inc; 2006. p. 1-23.
10. Chou T, Cornacchio D, Cooper-Vince CE, Crum K, Comer JS. DSM-5 and the assessment of childhood anxiety disorders: Meaningful progress or persistent diagnostic quagmires? *Psychopathology Review*. Under Review.
11. Wittchen H, Gloster AT, Beesdo-Baum K, Fava GA, Craske MG. Agoraphobia: A review of the diagnostic classificatory position and criteria. *Depress Anxiety*. 2010; 27(2):113–133. DOI: 10.1002/da.20646 [PubMed: 20143426]
12. American Psychiatric Association. *Diagnostic and statistical manual of mental disorders*. 4. Washington, DC: American Psychiatric Association; 2000. text revision
13. American Psychiatric Association. *Diagnostic and statistical manual of mental disorders*. 5. Washington, DC: American Psychiatric Association; 2013.
14. World Health Organization. *International statistical classification of diseases and related health problems*. 10. New York, NY: World Health Organization; 2008. Revised
15. Antony MM, Brown TA, Barlow DH. Heterogeneity among specific phobia types in DSM-IV. *Behav Res Ther*. 1997; 35(12):1089–1100. DOI: 10.1016/S0005-7967(97)80003-4 [PubMed: 9465442]
16. Burstein M, Georgiades K, He J, et al. Specific phobia among U.S. adolescents: Phenomenology and typology. *Depress Anxiety*. 2012; 29(12):1072–1082. DOI: 10.1002/da.22008 [PubMed: 23108894]

17. LeBeau RT, Glenn D, Liao B, et al. Specific phobia: A review of DSM-IV specific phobia and preliminary recommendations for DSM-V. *Depress Anxiety*. 2010; 27(2):148–167. DOI: 10.1002/da.20655 [PubMed: 20099272]
18. Silverman, WK., Albano, AM. *The Anxiety Disorders Interview Schedule for Children for DSM-IV: Child and Parent Versions*. San Antonio, TX: Psychological Corporation; 1997.
19. Comer JS, Kendall PC. A symptom-level examination of parent-child agreement in the diagnosis of anxious youths. *J Am Acad Child Adolesc Psychiatry*. 2004; 43(7):878–886. DOI: 10.1097/01.chi.0000125092.35109.c5 [PubMed: 15213589]
20. Silverman WK, Ollendick TH. Evidence-based assessment of anxiety and its disorders in children and adolescents. *J Clin Child Adolesc Psychol*. 2005; (3):380–411. DOI: 10.1207/s15374424jccp3403_2 [PubMed: 16026211]
21. Wood JJ, Piacentini JC, Bergman RL, McCracken J, Barrios V. Concurrent validity of the anxiety disorders section of the anxiety disorders interview schedule for DSM-IV: Child and parent versions. *J Clin Child Adolesc Psychol*. 2002; 31(3):335–342. DOI: 10.1207/S15374424JCCP3103_05 [PubMed: 12149971]
22. Achenbach, TM., Rescorla, LA. *Manual for the ASEBA School-Age Forms & Profiles*. Burlington, VT: University of Vermont, Research Center for Children, Youth, and Families; 2001.
23. March JS, Parker JDA, Sullivan K, Stallings P, Conners CK. The multidimensional anxiety scale for children (MASC): Factor structure, reliability, and validity. *J Amer Acad Child Adolesc Psychiatry*. 1997; 36(4):554–565. DOI: 10.1097/00004583-199704000-00019 [PubMed: 9100431]
24. March JS, Albano AM. New developments in assessing pediatric anxiety disorders. *Advan Clin Child Psychol*. 1998; 20:213–241. DOI: 10.1007/978-1-4757-9038-2_7
25. March JS, Sullivan K, Parker J. Test–retest reliability of the multidimensional anxiety scale for children. *J Anxiety Disord*. 1999; 13(4):349–358. DOI: 10.1016/S0887-6185(99)00009-2 [PubMed: 10504106]
26. Kovacs, M. *The Children's Depression Inventory Manual*. North Tonawanda, NY: Multihealth Systems; 1992.
27. Comer JS, Kendall PC. High-end specificity of the children's depression inventory in a sample of anxiety-disordered youth. *Depress Anxiety*. 2005; 22(1):11–19. DOI: 10.1002/da.20059 [PubMed: 15965988]
28. Finch AJ, Saylor CF, Edwards GL. Children's depression inventory: Sex and grade norms for normal children. *J Consult Clin Psychol*. 1985; 53(3):424–425. DOI: 10.1037//0022-006X.53.3.424 [PubMed: 4008727]
29. Ollendick TH, Yule W. Depression in British and American children and its relation to anxiety and fear. *J Consult Clin Psychol*. 1990; 58(1):126–129. DOI: 10.1037/0022-006X.58.1.126 [PubMed: 2319046]
30. Smucker MR, Craighead WE, Craighead LW, Green BJ. Normative and reliability data for the children's depression inventory. *J Abnorm Child Psychol*. 1986; 14(1):25–39. DOI: 10.1007/BF00917219 [PubMed: 3950219]
31. Finch AJ, Saylor CF, Edwards GL, McIntosh JA. Children's depression inventory: Reliability over repeated administrations. *J Clin Child Psychol*. 1987; 16(4):339–341. DOI: 10.1207/s15374424jccp1604_7
32. Kazdin AE. Children's depression scale: Validation with child psychiatric inpatients. *J Child Psychol Psychiatry*. 1987; 28(1):29–41. DOI: 10.1111/j.1469-7610.1987.tb00650.x [PubMed: 3558537]
33. Nelson WM, Politano PM. Children's depression inventory: Stability over repeated administrations in psychiatric inpatient children. *J Clin Child Psychol*. 1990; 19(3):254–256. DOI: 10.1207/s15374424jccp1903_8
34. Silverman WK, Fleisig W, Rabian B, Peterson RA. Child anxiety sensitivity index. *J Clin Child Psychol*. 1991; 20(2):162–168. DOI: 10.1207/s15374424jccp2002_7
35. Bernstein A, Zvolensky MJ, Stewart SH, Comeau MN, Leen-Feldner E. Anxiety sensitivity taxonicity across gender among youth. *Behav Res Ther*. 2006; 44(5):679–698. DOI: 10.1016/j.brat.2005.03.011 [PubMed: 16098477]

36. Stinson FS, Dawson DA, Chou SP, et al. The epidemiology of DSM-IV specific phobia in the USA: Result from the national epidemiologic survey on alcohol and related conditions. *Psychol Med*. 2007; 37(7):1047–1059. [PubMed: 17335637]
37. Kendall, PC., Hedtke, KA. Cognitive behavioral therapy for anxious children, Therapist manual. 3. Ardmore, PA: Workbook Publishing; 2006.
38. Pincus, DB., Ehrenreich, JT., Mattis, SG. Mastery of anxiety and panic for adolescents: Riding the wave (Therapist guide). New York, NY: Oxford Press; 2008.
39. Rynn M, Puliafico AC, Heleniak C, Rikhi P, Ghalib K, Vidair H. Advances in pharmacotherapy for pediatric anxiety disorders. *Depress Anxiety*. 2011; 28:76–87. DOI: 10.1002/da.20769 [PubMed: 21225851]
40. White KS, Payne LA, Gorman JM, et al. Does maintenance CBT contribute to long-term treatment response of panic disorder with or without agoraphobia? A randomized controlled clinical trial. *J Consult Clin Psychol*. 2013; 81:47–57. DOI: 10.1037/a0030666 [PubMed: 23127290]

Table 1

Demographic and clinical characteristics of agoraphobic youth who do and do not meet the DSM-5 agoraphobia criterion A and who meet for specific phobia in a sample of treatment-seeking anxious youth

	Agoraphobic youth meeting DSM-5 agoraphobia definition (N=63)		Agoraphobic youth <i>not</i> meeting DSM-5 agoraphobia definition (N=20)		Specific phobic youth (N=68)		Significance test
	N	%	N	%	N	%	
Gender							$\chi^2(2, N=151) = .29$
Female	39	61.9	13	65.0	40	58.8	
Male	24	38.1	7	35.0	28	41.2	
Race/ethnicity							$\chi^2(2, N=151) = 7.04$
Non-Hispanic White	52	82.5	15	75.0	59	86.8	
Minority	11	17.5	5	25.0	9	13.2	
	Mean	SD	Mean	SD	Mean	SD	Significance test
Age	13.8	2.7	14.5	2.5	11.16	2.92	$F(2,148) = 19.32^{***}$

Note: The term "agoraphobic youth" refers to children and adolescents with symptom presentations meeting the DSM-IV definition of agoraphobia (albeit agoraphobia was not an independently codable disorder in DSM-IV).

* $p < .05$,

** $p < .01$,

*** $p < .001$

Table 2

Clinical characteristics across agoraphobic youth who do and do not meet the DSM-5 agoraphobia criterion A and who meet for specific phobia in a sample of treatment-seeking anxious youth

	Agoraphobic youth meeting DSM-5 agoraphobia definition (N=63)		Agoraphobic youth <i>not</i> meeting DSM-5 agoraphobia definition (N=20)		Specific phobic youth (N=68)		Significance test
	M	SD	M	SD	M	SD	
Principal diagnosis CSR	5.97 ^a	.82	5.70 ^{ab}	.98	5.29 ^b	.98	$F(2,146) = 5.29^{**}$
Total anxiety	55.29 ^a	19.89	46.70 ^a	16.33	46.59 ^a	15.50	$F(2,132) = 2.17$
Somatic complaints	8.21 ^a	3.92	7.40 ^{ab}	4.26	5.27 ^b	3.59	$F(2,132) = 3.31^*$
Agoraphobic avoidance	5.97 ^a	4.00	1.60 ^b	2.11	.43 ^b	1.31	$F(2,146) = 48.46^{***}$
Anxiety sensitivity	35.68 ^a	6.90	33.70 ^a	6.11	27.68 ^b	6.01	$F(2,122) = 12.76^{***}$
Internalizing psychopathology	68.71 ^a	8.31	67.53 ^a	6.35	63.02 ^b	9.19	$F(2,127) = 4.87^{**}$
Depressive symptoms	11.23 ^a	6.87	9.85 ^a	6.85	7.22 ^a	6.37	$F(2,126) = .52$
Social functioning	57.58 ^a	7.31	57.74 ^a	8.53	57.32 ^a	8.90	$F(2,128) = .28$

Note: The term "agoraphobic youth" refers to children and adolescents with symptom presentations meeting the DSM-IV definition of agoraphobia (albeit agoraphobia was not an independently codable disorder in DSM-IV); CSR = Clinical Severity Rating (as determined by the Anxiety Disorder Interview Schedule for Children); total anxiety and somatic complaints were drawn from the Multidimensional Anxiety Scale for Children Total Score and Somatic Complaints subscale, respectively; Internalizing psychopathology and Social functioning were drawn from the Child Behavior Checklist Internalizing T-score and Social Functioning T-score, respectively; Anxiety sensitivity was drawn from the Children's Anxiety Sensitivity Index; Depressive symptoms drawn from total score of the Children's Depression Inventory. Within a row, values with different superscript letters are significantly different.

* $p < .05$,

** $p < .01$,

*** $p < .001$