Agoraphobia in an evolutionary context

I was interested in Bracha et al’s postulation that agoraphobia might be a result of evolutionary bias towards safety-seeking among plain-living and more spaces, not just about open spaces, but about places where they might be open to others to ‘embarrass themselves’, usually by vomiting, fainting, or screaming out loud. Their overwhelming desire to return home seems to be as much about being hidden from others of the same species as about safety from predators. The explanation I favour is that signs of illness would possibly result in, at best, being excluded from the tribe, and, at worst, being killed and disposed of, both because of the risk of infecting or damaging the rest of the tribe. This is also, of course, related to past and present stigma and understanding of mental illness and unusual phenomena.

My patients have found this a very helpful, rational explanation which has helped them to start making sense of that feels like irrational, uncontrollable behaviour. I will now also include Bracha et al’s explanation and see which has more face validity.


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Authors’ reply: The patients Cornish describes probably have the post-traumatic stress disorder-like secondary agoraphobia (also known as conditioned, acquired, post-traumatic, memory-trace-overconsolidation-based agoraphobia), not the rarer primary (also known as innate prepotentiated) agoraphobia.

As we have proposed (Bracha, 2006; Bracha et al, 2006a,b), both primary and secondary agoraphobia should be taken out of the panic disorder section of DSM-VICD-11. Primary agoraphobia (i.e. with no prior Criterion A traumatic event) should be categorised with the other innate-specific phobias and secondary (post-traumatic) agoraphobia should be categorised alongside (a more narrowly defined) post-traumatic stress disorder (PTSD) in a new sub-category of anxiety/stress/asthmatic disorders entitled ‘overconsolidation-related fears’. Contrary to dogma, evolutionary hypotheses are testable (Bracha et al, 2005; Bracha, 2006; Bracha & Hayashi, 2006; Bracha et al, 2006b).

The attacks away from home are not the sole Criterion A event which (if untreated) are often followed by secondary (memory-trace-overconsolidation-based) agoraphobia. Secondary agoraphobia frequently follows embarrassing experiences away from home, related to psychiatric and non-psychiatric conditions such as chronic motor or vocal tic disorder, trichotillomania, narcolepsy, grand mal seizures, etc. Criterion A experiences (‘events’) such as being bullied, ridiculed, threatened or physically assaulted by school or neighbourhood peers are also often followed by the PTSD-like secondary agoraphobia.

Another diagnosis Cornish should consider is social phobia (i.e. innate fear of simultaneous visual scrutiny by a large group of strangers). During much of the human era of evolutionary adaptedness, being stared at by a large group of non-smiling, non-kin conspecifics was more likely than not to be followed by negative consequences (Bracha, 2006). Evolution is not forward looking and could not anticipate a future where being stared at by a large group of non-smiling strangers might be followed by receiving an honorarium rather than by injury or death.

Most importantly, both the dimensional and categorical approaches planned for DSM-VICD-11 should include an evolution-inspired ‘innateness axis’ modelled on Axis V (the global assessment of functioning axis). The dimensional innateness axis score would reflect the clinician’s estimate (based on past psychiatric history, genetic history, age at onset, etc.) of the likely ‘hardwiredness’ of a particular patient’s symptoms (with low scores indicating a mostly post-traumatic, overconsolidation-related aetiology and high scores indicating a mostly evolutionarily hardwired aetiology).