**VP 08 CHEAT SHEET**

# Functional Dizziness — Cheat Sheet for Physiotherapists

*Identify positive signs, communicate compassionately, build the graded exposure hierarchy, integrate CBT.*

### ► Why functional dizziness matters

*Functional dizziness accounts for up to one third of dizziness clinic presentations. Predictive-coding miscalibration with threat amplification — biologically real, treatable. Physiotherapy-led graded exposure plus CBT integration produces 50–70% significant improvement or resolution.*

## Indications — when this approach fits

### ► When to use this pathway

► Normal vestibular tests (vHIT, caloric, VEMP) with positive functional signs and dramatic symptom variability.
► Give-way patterns and dissociation between reported and observed function on examination.
► Distinguish from PPPD (visual-motion driven) and structural causes; include patients with comorbid anxiety, depression or trauma history (with psychology referral).

## Why predictive miscalibration generates dizziness

| Mechanism | Source | Result |
|---|---|---|
| Sensory prediction | Brain forecasts head and body input | Discrepancy when prediction is wrong |
| Threat amplification | Limbic over-weighting of mismatch | Symptoms feel real and dangerous |
| Hypervigilance | Somatic attention reinforces the signal | Symptoms persist and grow |
| Recalibration loop | Repeated exposure resets the model | 50–70% significant improvement |

### ► Pearl: diagnose on positive signs

*Functional dizziness is identified, not excluded. Document give-way weakness with normal isolated strength, midline-crossing difficulty, distractibility on dual-task, functional tremor entrainment, and Hoover sign at session one — these become the patient's evidence base when symptoms flare.*

## Assessment battery

| Domain | Test | Notes |
|---|---|---|
| Positive signs | Give-way, midline-cross, distractibility, tremor, Hoover | Diagnostic backbone — document each finding |
| Handicap | DHI total + subscales | Track severity and pattern |
| Confidence | ABC scale | Falls risk and avoidance proxy |
| Mood | PHQ-9 + GAD-7 | Comorbid anxiety/depression screen |
| Trauma | Brief PTSD screen | Refer psychology if positive |
| Self-report | DHI + dizziness VAS | Baseline for re-test |

## Prescription / treatment cheat list

| Category | Frequency | Duration | Progress when… |
|---|---|---|---|
| Distraction-based exposure | Daily | 10–30 min | Symptoms shift on dual-task |
| Behavioural activation | 3–5x weekly | Value-tied tasks | Anxiety drops 50% on hierarchy |
| Graded hierarchy | Weekly review | Progress on anxiety scores | 3 sessions less than 50% baseline |
| Functional win at session 1 | Once | Single value-driven task | Engagement up at week 2 |
| Mood + trauma referral | As needed | Concurrent with rehab | Depression or trauma flagged |

### ► Pearl: symptom rule

*Mild-to-moderate symptoms that settle within 30 minutes are the dose. Severe symptoms persisting past 30 minutes mean back off, do not stop. No symptoms means no signal — push the next item up the hierarchy. Vestibular suppressants beyond 72 hours blunt plasticity.*

### ► Red flags — escalate

*Vertical or direction-changing nystagmus, truncal ataxia, asymmetric hearing loss, central signs, severe deteriorating mood, emergent suicidal ideation → refer vestibular physician or psychiatry urgently; functional label requires absence of these features.*

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## Outcome measures — re-test every 4–6 weeks

| Domain | Tool | MCID / threshold |
|---|---|---|
| Handicap | Dizziness Handicap Inventory | Drop of 18+ points clinically meaningful |
| Confidence | ABC scale | Less than 67% = falls risk; 10+ pt gain meaningful |
| Visual sensitivity | VVAS | Drop of 9+ points clinically meaningful |
| Functional balance | FGA | Up 4 points clinically meaningful |
| Mood | PHQ-9 / GAD-7 | Comorbid anxiety or depression flag |

### ► Compliance — what helps adherence

*Open with the predictive-coding rationale — patients respond when they hear "your nervous system is misinterpreting sensory signals". Engineer one functional win at session 1. Pair distraction-based exposure (task focus, music) with a written and video home program; week-2 telehealth check-in halves drop-out.*

### ► When to refer onward

- ► No improvement by 6 weeks → re-screen for vestibular hypofunction with vHIT or caloric.
- ► Significant comorbid trauma, dissociation or depression → clinical psychology / CBT referral.
- ► Antidepressant consideration if comorbid mood disorder → vestibular physician or GP.
- ► New hearing red flags or focal neurology → ENT or neurology urgently.

### ► Twelve-second tips

*Use 'functional', not 'psychogenic'. Diagnose on positive signs. Distract from soma during exposure. Tie hierarchy to patient values. Mild-moderate is the dose. Plateaus need perpetuating-factor review before program change.*

### ► Common pitfalls — and how to avoid them

- ► Continuing to exclude after multiple positive signs are present.
- ► Somatic-attention exercises that reinforce hypervigilance and threat focus.
- ► Generic balance lists without value-tied goals.
- ► Pushing through panic-level anxiety instead of titrating dose.
- ► Missing comorbid trauma or depression that perpetuate symptoms.

### ► Special populations

- ► Adolescents — engage parents, screen for trauma and family stressors.
- ► Comorbid POTS — coordinate with cardiology; address autonomic load in parallel.
- ► Post-concussion overlap — consider VOMS battery alongside functional signs.
- ► Older adults — address falls risk separately from functional pattern.

### ► Patient communication scripts

*"Your nervous system is misinterpreting sensory signals — that creates real dizziness." | "Think of a faulty traffic light on a safe road — fixing the light fixes the dizziness." | "Your test results are normal — that confirms the diagnosis, not excludes it."*

### ► References / further reading


- ► Stone J. Functional neurologic disorders. Continuum 2015;21(3):818–37.
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- ► Nielsen G et al. Physiotherapy for functional motor disorders. JNNP 2015;86(10):1113–9.
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