

**VP 10  
CHEAT  
SHEET**

**PPPD Rehabilitation — Cheat Sheet for Physiotherapists**

*Diagnose with Bárány criteria; treat with triple-track therapy: graded exposure, CBT integration, and SSRI/SNRI coordination.*

► **Why PPPD rehabilitation matters**

*PPPD is the most common cause of chronic functional dizziness in adult practice. Symptoms are genuine and disabling despite normal vestibular testing. Physiotherapy-led graded exposure plus CBT integration and SSRI/SNRI coordination produces 70–80% substantial improvement and 50–60% complete resolution in optimally managed cases.*

**Indications — when this approach fits**

► **When to use this pathway**

- Dizziness or unsteadiness for over fifty percent of days for at least three months.
- Worse with upright posture, motion, and visually complex environments (the Bárány triad).
- Identifiable precipitant — acute vestibular insult, panic attack, mTBI, or illness.

**Bárány 2017 diagnostic criteria**

Criterion	Threshold	Notes
Duration	≥ 3 months	Dizziness or unsteadiness on more than half of days
Persistence	Daily or near-daily	Persistent, not episodic vertigo attacks
Provocation	Upright + motion + visual complexity	Symptoms worsen with all three triggers
Precipitant	Vestibular / anxiety / mTBI / illness	Symptoms outlast the trigger that caused them

► **Pearl: diagnose by pattern**

*PPPD is a positive diagnosis based on the Bárány triad — upright posture, motion, and visual complexity all worsening symptoms in someone with a precipitant. Normal testing supports rather than excludes the diagnosis. Reassure the patient that symptoms are real, treatable, and not "in their head".*

**Assessment battery**

Domain	Tool	Notes
Visual sensitivity	Visual Vertigo Analogue Scale (VVAS)	High-yield in PPPD — score 50–80 / 140 typical
Handicap	Dizziness Handicap Inventory (DHI)	Total and functional / emotional subscale pattern
Confidence	Activities-specific Balance Confidence (ABC)	Avoidance proxy; falls-risk if under 67%
Falls fear	Falls Efficacy Scale-International (FES-I)	Fear-of-falling driver of avoidance
Mood	PHQ-9 + GAD-7	Comorbid depression / anxiety screen
Trauma	Brief PTSD or trauma screen	Refer psychology if positive

**Triple-track therapy programme**

Track	Frequency	Duration	Progress when...
Graded exposure hierarchy	Daily	30–60 min	Anxiety drops ≥ 50% on 3 consecutive sessions
Visual desensitisation	3–5× weekly	1–5 min, escalating	Tolerates dynamic optokinetic flow
Balance retraining	3–5× weekly	10–15 min	Stable on foam, eyes-closed and dual-task
CBT integration	Weekly	45–60 min	Catastrophic thinking ↓; engagement ↑
SSRI / SNRI coordination	Daily (GP)	Onset 4–8 weeks	Mood improves; rehab tolerance ↑

► **Pearl: in-session anxiety curve**

*Anxiety rises in the first 10–30 minutes of each exposure session, then settles over 30–60 minutes — that drop is the therapeutic dose. If anxiety escalates to panic, scale back one rung rather than abandon the session. Pace is patient-led; progression is non-negotiable.*

► **Red flags — escalate**

*New vertical or direction-changing nystagmus, asymmetric hearing loss, focal neurology, severe deteriorating mood, suicidal ideation, or failure to improve at 12 weeks → refer to a vestibular physician, psychiatry, or ENT as the pattern dictates.*

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

Domain	Tool	MCID / threshold
Visual sensitivity	VVAS	Drop of 9+ points clinically meaningful
Handicap	DHI	Drop of 18+ points clinically meaningful
Confidence	ABC scale	Under 67% = falls risk; 10+ point gain meaningful
Falls fear	FES-I	Drop tracks avoidance reduction
Mood	PHQ-9 / GAD-7	Comorbid anxiety or depression flag

► **Compliance — what helps adherence**

*Open every session with the predictive-coding rationale ("your brain is over-predicting threat — exposure rebuilds the prediction"). Pair exposure with a value-tied real-world task. A written + video home programme and a week-2 telehealth check-in halves drop-out. Combination physiotherapy + SSRI outperforms either alone.*

► **When to refer onward**

- No improvement at 6 weeks → re-screen for vestibular hypofunction with vHIT and caloric.
- Significant comorbid trauma, dissociation, or severe depression → clinical psychology / CBT specialist.
- Antidepressant consideration if mood is comorbid → vestibular physician or GP for SSRI/SNRI.
- New hearing red flags or focal neurology → ENT or neurology urgently.
- No response at 12 weeks combination care → vestibular physician for diagnostic review.

► **Twelve-second tips**

*Call it PPPD — patients tolerate a real label far better than "no diagnosis". Open with the predictive-coding script. Build the hierarchy with the patient. Mild-to-moderate symptoms during exposure are the dose; panic is the cap. Coordinate the SSRI early — do not save it as a last resort.*

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

- Treating PPPD like peripheral hypofunction — generic gaze stabilisation does not reset the prediction.
- Pushing through panic-level anxiety instead of titrating dose.
- Reinforcing avoidance with "rest until you feel better" advice.
- Missing comorbid anxiety, depression, or trauma that perpetuates the loop.
- Delaying SSRI/SNRI as a "last resort" — combination outperforms physiotherapy alone.

► **Special populations**

- Post-vestibular-neuritis PPPD — most common precipitant; start hierarchy early once acute symptoms settle.
- Post-mTBI PPPD — coordinate with concussion clinic; visual desensitisation is high-yield.
- Comorbid vestibular migraine — control migraine first; CGRP-class triggers worsen visual dependence.
- Older adults — pair with falls prevention; FES-I drives the avoidance conversation.
- Adolescents — engage parents in the predictive-coding script and the home programme.

► **Patient communication scripts**

*"Your balance organs are working — the brain is over-predicting threat from normal signals." | "Symptoms during exposure mean the rehabilitation is working, not that you are getting worse." | "Your test results are normal — that confirms the diagnosis, not absence of disease."*

► **References / further reading**

- Staab JP et al. Diagnostic criteria for persistent postural-perceptual dizziness (PPPD). *J Vestib Res.* 2017;27(4):191–208.
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