Revisiting the Standard of Care in Vestibular Rehabilitation

By Dr. James Mortensen, PT, DPT

Vestibular rehabilitation has evolved significantly over the last two decades. What was once considered a niche area of physical therapy has become a highly specialized field supported by robust clinical practice guidelines, growing research, and increasingly sophisticated diagnostic technologies. Despite these advances, I continue to see patients who have been misdiagnosed, undertreated, or treated using outdated approaches that fail to address the true drivers of their symptoms. As clinicians, we have an obligation to periodically revisit what constitutes the current standard of care and critically evaluate whether our practices align with the best available evidence.

The Standard of Care Is Not Static

One of the most common misconceptions in healthcare is that standard of care is synonymous with common practice. It is not. Standard of care reflects what a reasonably skilled clinician with similar training would do under similar circumstances based on current evidence and accepted clinical guidelines. As new evidence emerges, the standard evolves. In vestibular rehabilitation, this evolution has been dramatic. Twenty years ago, many patients with dizziness were routinely told to rest, avoid movement, or simply wait for symptoms to improve. Today, we know that prolonged avoidance behaviors often contribute to chronic dizziness, visual dependence, deconditioning, and persistent disability. Current evidence strongly supports early identification of vestibular disorders, targeted rehabilitation, patient education, and progressive exposure to symptom-provoking activities when appropriate.

The Importance of Accurate Differential Diagnosis

One of the greatest challenges in vestibular rehabilitation is recognizing that dizziness is not a diagnosis. Patients frequently arrive having been labeled with vague terms such as vertigo, dizziness, balance disorder, or vestibular dysfunction. These descriptions identify symptoms rather than pathology. The modern vestibular clinician must differentiate between conditions such as BPPV, vestibular neuritis, labyrinthitis, vestibular migraine, PPPD, cervicogenic dizziness, bilateral vestibular hypofunction, concussion-related vestibular dysfunction, functional neurological disorders, and central nervous system pathology. Each diagnosis requires a different treatment strategy.

Comprehensive Assessment Remains the Foundation

A comprehensive vestibular assessment should include a detailed subjective history, oculomotor examination, positional testing when indicated, vestibulo-ocular reflex assessment, balance and gait analysis, fall risk screening, cervical spine assessment, functional outcome measures, and screening for central nervous system involvement. The subjective examination often provides more diagnostic information than any individual test.

Technology Should Support Clinical Judgment

Modern vestibular clinics have access to tools that were unavailable to previous generations of therapists, including computerized dynamic posturography, video head impulse testing, infrared video goggles, dynamic visual acuity testing, and sensory organization testing. These tools provide valuable objective data but should never replace clinical reasoning. Technology should confirm, quantify, and refine clinical impressions rather than drive them.

Treat the Patient, Not Just the Vestibular System

Many patients present with multiple overlapping contributors, including cervical dysfunction, migraine disorders, visual impairments, anxiety, deconditioning, chronic pain, orthopedic limitations, and cardiovascular factors. Successful rehabilitation requires identifying and addressing every contributor to a patient's functional limitations rather than focusing exclusively on vestibular pathology.

Outcome Measures Matter

Clinicians should be able to demonstrate meaningful change. Outcome measures such as the Dizziness Handicap Inventory, Activities-specific Balance Confidence Scale, Functional Gait Assessment, Dynamic Gait Index, mCTSIB, and FOTO help identify impairments, track improvement, and justify continued skilled intervention.

Patient Education Is a Skilled Intervention

Many patients arrive fearful of movement, convinced they are causing damage, or frustrated by symptoms that have persisted for months or years. Helping patients understand why symptoms occur, how compensation develops, why exposure is necessary, and what recovery should realistically look like can significantly improve adherence and outcomes.

Looking Forward

Vestibular rehabilitation continues to advance at an impressive pace. Emerging research in sensory integration, concussion management, vestibular migraine, persistent dizziness syndromes, and neuroplasticity is expanding our understanding of how patients recover. The standard of care is ultimately about delivering the right intervention, to the right patient, at the right time, based on the best available evidence. When we commit to that process, we improve outcomes, reduce disability, and provide the level of care our patients deserve.