Life Rebalanced Live 2024

NEUROLOGIC REHABILITATION FOR VESTIBULAR DISORDERS

CYNTHIA RYAN: Hello, and welcome to the final day of the Vestibular Disorders Association's Fourth annual Life Rebalanced Live Virtual Conference. I'm Cynthia Ryan, executive director of VeDA. This has been an amazing week. And it's gone by all too quickly.

Yesterday we had another great discussion. This one about bilateral vestibular hypofunction. Basically no vestibular function. Can't even imagine that. It's just debilitating. Dr. Raymond van de Berg shared updates on cutting-edge research into the vestibular implant, which was fascinating. If you haven't checked that out, go back and look at some of the resources that are on the community board. And Dr. Amanda Chiao explained how children with vestibular dysfunction adapt and compensate for their vestibular loss.

Our patient panelists were also so inspiring yet again. A big shout-out to Lynn Johnson, one of our VeDA board members who made me cry with her story about how a serious fall inspired her to reframe her vestibular limitations. And I think you can all relate to Kalyn Asher's challenges of swaying back and forth while navigating narrow sidewalks. We all agreed that everyone needs to go out and get VeDA's "Dizzy, Not Drunk" T-shirts.

I'd like to start again today by thanking our sponsors who truly do make this event possible. The James D. and Linda B. Hainlen Discovery Fund and the University of Minnesota's Department of Otolaryngology have generously supported LRL since its inception in 2020. A special shout-out to Jim Hainlen who is a vestibular patient.

He inspired this event by holding his own vestibular conference in 2018 and 2019 in Minneapolis, Minnesota. Jim cares deeply about supporting people on their vestibular

journey. And it was important to him to not only educate people about vestibular disorders but provide a platform where people can connect like they have done this week. I heard so many comments from people in the chat saying, how can we still stay in connection after this conference?

Another big Thanks to Dr. Abbie Ross and Dr. Danielle Tolman from Balancing Act Rehabilitation, who are also generously sponsoring this year's event. Many of you know Abbie and Danielle as the hosts of the conference. And some of you may know them as the hosts of the Talk Dizzy to Me Podcast.

But what you may not know is that Abbie and Danielle serve on VeDA's Board of Directors and have volunteered countless hours to advance vestibular advocacy. Its dedicated volunteers like Abbie and Danielle that are the lifeblood of VeDA. I have been honored to work with them and glad to call them my friends.

Abbie and Danielle, thank you for everything you do for VeDA and the vestibular community. Thanks also to the Academy of Doctors of Audiology for sponsoring this year's event. And a personal thank you to Pamela Duncan, who attended last year's event and was inspired to make a donation to support this year's event as well.

And now I'd like to pass it off to our hosts, Dr. Abbie Ross and Danielle Tolman.

DANIELLE TOLMAN: Thank you so much for the wonderful introduction, Cynthia. I cannot believe we are on the last day of the Fourth Annual Life Rebalanced Live. This week has just flown by. We are wrapping up today still with an all-star lineup of health care providers to discuss various topics pertaining to the management of vestibular dysfunction as well as inspirational patients who will be sharing their vestibular journeys.

We also, of course, want to say thank you to all of you who have contributed to this conference in some way, including VeDA's donors, staff, and volunteers.

ABBIE ROSS: And with their contributions, we're able to put the live version of the conference on at no cost to our attendees. If you wish to gain lifetime access to the

presentations following our live event, we will have them available for purchase for just $55. And thank you to all of you who have purchased thus far. Your financial support helps VeDA's continued mission to spread vestibular awareness.

Now we're at day 5, the final day of 2024 Life Rebalanced Live. And we have a topic that's very near and dear to Danny and I's heart. It's neurologic rehabilitation for vestibular disorders. We'll be discussing what to look for in finding a qualified therapist, how vestibular rehab fits under the umbrella of neurologic rehab, and how does vestibular therapy even work.

DANIELLE TOLMAN: So without further ado, I'm very excited to introduce our next guest, Dr. Rachel Wellons. Dr. Wellons is a board-certified specialist in neurologic physical therapy and has completed the APTA vestibular rehabilitation competency and advanced vestibular rehabilitation courses.

Dr. Wellons ran the vestibular rehabilitation program at Thomas Jefferson University Hospital from 2006 to 2010. She is also an associate professor of physical therapy at Louisiana State University Health Sciences Center New Orleans. Dr. Wellons has been involved with the Vestibular Special Interest Group of the Academy of Neurologic Physical Therapy for over 10 years, serving as the podcast coordinator, online educational coordinator, and chair.

She has also published research and presented posters in the area of clinical translational research with respect to balance and vestibular disorders, interprofessional education, case-based learning, and strategies to increase clinical reasoning in physical therapy education. Dr. Wellons maintains an active clinical practice on the LSU Health Science Center campus, treating individuals with vestibular disorders, imbalance, and neurologic disorders in a faculty practice clinic.

Dr. Wellons, thank you. Thank you. Thank you for being here with us today. We are so excited to dive in. This is going to be a lot of fun today.

RACHEL WELLONS: Great. I'm really excited to be here. Thank you, again, for having me.

ABBIE ROSS: Thank you, Dr. Wellons, for being here. Let's jump right in and start broad. When we think about physical therapy, we have general physical therapy. And then if we narrow it down, it's neurologic physical therapy. And then if we narrow it down again, it's vestibular physical therapy. Can you define each of those?

RACHEL WELLONS: Sure, no problem. And I think by defining them, it's really important to talk about the training of a physical therapist in general and the training, of course, as one gets more advanced. So for those of you who may not know, physical therapy now is a doctoral level program. So our students go to four years of undergraduate degree. And then they come to physical therapy school. It's typically for about three years.

The goal of physical therapy school is to train a physical therapist to be a generalist. So that means that they can jump into any practice setting-- musculoskeletal, acute care, neurologic setting. And they can be able to handle most basic cases and then, of course, would need mentorship to handle more advanced cases.

So as a physical therapist has interest in one particular area, they may focus their practice in that area. So if someone is interested in neurologic rehabilitation, they'll work in a setting where they'll primarily work with patients with neurologic dysfunction. They'll go to continuing education and pursue greater certifications that way.

And so for those of you who might not be aware of what is neurologic physical therapy-- so the neurologic physical therapy is physical therapy which treats disorders or disease of the neurologic system. It includes the brain, the spinal cord, or the nerves. And damage or disease in these areas often results in an individual having inability or difficulty to walk, balance, think, or coordinate movement.

So going from there, vestibular rehabilitation is even more of a niche area. So when we think of physical therapists in general, we look at the numbers of all physical therapists in the country. Nearly half of physical therapists practice in musculoskeletal practice in an outpatient orthopedic setting.

And when you say physical therapy, to be honest, that's what most people think. When I introduce myself as a physical therapist, people always say, oh, well, my knee hurts and

my shoulder hurts. And I say, well, I'm not the person you want to be answering that question. But anyway.

So neurologic rehabilitation is already a smaller area of practice than orthopedics. And then vestibular rehabilitation is even a smaller subset of neurologic rehabilitation where we're really just focusing on our vestibular system, which, of course, is our peripheral vestibular system and organs and how the system integrates with the brain.

DANIELLE TOLMAN: And even just in neurologic, PT is a very vast difference in diagnoses.

RACHEL WELLONS: Exactly.

DANIELLE TOLMAN: So it could be from stroke to traumatic brain injury to progressive neurological diseases. I mean, that's a huge field to begin with. So coming down to that vestibular aspect can be very specializing in that sense.

So if somebody were looking for a physical therapist with neurologic rehabilitation training, what kind of credentials could they look for? What type of things might we want to keep an eye out for on websites if we're trying to determine who to work with?

RACHEL WELLONS: Definitely. And I think that's really important for the public to be able to know. So our specialty accrediting agency is called the American Board of Physical Therapy Specialists or ABPTS. In order to find that website, it's abpts.org.

So if a physical therapist has specialized in neurologic rehabilitation, if they've practiced so many hours or done a residency, they can then choose to challenge themselves by taking a very difficult test. And if they pass that test, they are said to be a board-certified neurologic physical therapist. You can go to the website ABPTS. You can search by your area and click Neurologic Specialty. And that's how you can find them. I think there are approximately about 3,500 board-certified neurologic physical therapists in the United States.

Most often they will abbreviate the initials NCS you'll see after their name. But in the last few years, there's been a movement that with the lay public and they might not

understand what NCS is is to spell it out more specifically. So you will see it spelled out board-certified neurologic physical therapist.

ABBIE ROSS: Now when we talk about NCS or board-certified neurologic physical therapists, do all people with that credential specialize in vestibular rehabilitation? So since I took it, I'll speak just a little bit more in that you have to understand something about vestibular rehab. But does that mean that you're actually practicing with vestibular rehab regularly?

RACHEL WELLONS: Correct. To be honest-- and I have to say, I took the exam back in 2008. So it's been a hot second, and things changed since then. I personally found that vestibular rehabilitation was probably the fourth or fifth most common diagnosis that showed up on the exam. Things like stroke, spinal cord injury, and brain injury questions were vastly more representative.

So you, Abbie, is right, where you do have to understand parts of vestibular rehabilitation. And the vestibular rehabilitation questions that showed up personally, I thought, were a little bit easy for someone practicing in that area. So not all-- so that is to say not all therapists who have an NCS are going to know a lot about vestibular rehabilitation or are going to be very good in that area.

And certainly, it's to say, there are a lot of therapists out there who are practicing vestibular rehabilitation and doing a really great job who do not happen to have that NCS. Because personally, they have felt like they've just been in vestibular rehabilitation. And they don't have the general knowledge of things like stroke or spinal cord injury or brain injury to where they would want to take and pass that exam. So it can be very tricky indeed for the public to identify a high-quality provider.

DANIELLE TOLMAN: I can speak to that. I have primarily focused my clinical practice in vestibular rehab and balance dysfunction as it relates to other things like Parkinson's disease. But when it comes to, really, in-depth traumatic brain injury or really severe stroke rehab, it's definitely not as big into my specialty as vestibular rehab.

Now we do have an international audience. We have people from Australia yesterday and India and the UK and Canada. Are you aware of any equivalents in being board certified in different countries that people can look out for? Are you aware of that to your knowledge?

RACHEL WELLONS: To my knowledge, no. But I do know that there is a international group for neurologic physical therapists. So that would be a really great place to start and look for some of those certifications.

ABBIE ROSS: Now aside from, of course, VeDA's directory of finding someone practicing in vestibular rehab, what questions might a patient call an office and ask to determine, do they have a provider that is a good fit for their care?

RACHEL WELLONS: So I think the most easy questions and the most obvious question that people think about is that as a potential patient, you might ask someone, well, how many vestibular patients do you treat? Or what percent of your caseload is vestibular therapy? Or how long someone has been practicing.

Unfortunately, I would-- for some people who have been doing vestibular therapy for quite a long time but are not doing it well nor have they really advanced their practice very well-- so I feel like those questions aren't as valuable as some other questions are. I mean, I think they're certainly important. But those are not the only questions I would ask.

The questions, I think, are more important is I would want to ask the potential provider about what specific training they have had past their traditional physical therapy program. And most physical therapy programs-- again, when we think of the vast scope of physical therapy, there's so many things for us as professors to provide in just a short three-year time. And I would say, my students get a lot more vestibular than a lot of other students, just because they have me as a professor. And really what, it amounts to is about three weeks and three weeks in just one class.

So as an entry-level student, they're not really well prepared to take on very complex cases. I will train my students to take on the basic cases, to recognize the complex cases,

and to refer a patient to a more advanced provider. So I would as the potential patient ask the therapist what courses have they attended past their entry-level physical therapy program, what is the last continuing education course that they have attended to get some idea there.

The gold standard in terms of the physical therapy entry-level course for vestibular physical therapists is the Duke Emory APTA competency-based course in vestibular rehabilitation. It was originated by Dr. Susan Herdman. So some people will say the Herdman course. They will also call it the Emory course.

So I would say anyone who has attended that course unequivocally has my support. Johns Hopkins is also starting a wonderful entry-level course. And that is new. This is just the second year they're running it. Also University of Pittsburgh is running a course and certificate program. So those are places I would absolutely trust.

I would also ask the potential providers what resources do they read or consume in order to inform practice. Resources that are given-- again, there is bias in this because I am chair of the Vestibular SIG. But the Vestibular SIG and the Academy of Neurologic Physical Therapy have a high dedication to providing evidence-based information and evidence-based care. So if they are consuming resources from the ANPT, the Academy of Neurologic Physical Therapy, or the Vestibular SIG, Special Interest Group, those are going to be high-quality, evidence-based resources.

And I would also ask the therapist what professional organizations do they belong to. The Vestibular SIG is our premier organization. So if they are a member of that organization, that would give them a gold star in my book.

ABBIE ROSS: Also if they've heard of VeDA, that's a really good sign. Now if we move into actually what does rehab include, can you give us an overview of what vestibular therapy involves?

RACHEL WELLONS: Definitely. So the best vestibular therapists, of course, are going to start out with doing an exam. Even though many times we get referrals from providers

and a physician provider has done a differential diagnosis, a very good physical therapist will certainly take that into account. But they will do their own differential diagnosis.

A physical therapist will ask very detailed questions about the nature of their symptoms, what is causing them, what is exacerbating them to try to get down to the bottom of what's causing their symptoms. Then they will do a variety of tests. They will do a lot of tests, looking at your eyes, either with or without goggles, looking how your eyes move or your eyes focused on objects.

If you go to someone who calls himself a vestibular physical therapist and they do not look at your eyes at all, to me, that would be a big red flag. And I would turn back out of that clinic and walk on out because that is a really big part of what we do and is a big part of our specialty training as a vestibular physical therapist because many patients with vestibular dysfunction, of course, are going to have balance and gait problems.

So they will next do an assessment of balance or gait abilities. If you're giving off a history complaints consistent with this BPPV, then they may do canalith repositioning, exams or what we would call positional tests to see if BPPV may be your problem.

But basically, what really sets a vestibular physical therapy exam apart from a general neurologic physical therapy exam is we are trying to arrive at a differential diagnosis, whether that's a specific medical disorder, or we're really trying to nail down either neuroanatomically or pathophysiologically with either the structure or the function of the nervous system and have an explanation as to why your vestibular system is impaired.

You cannot give treatment unless you figured out the why it's impaired. And you can give treatment. It's not going to be a good treatment.

So once you figured out the why your vestibular system is impaired, then your physical therapist should come with a highly customized program that most often, you'll do on your own. But certainly, you'll come into the therapist's office, either weekly or every other week or connect via telehealth. It's great. We have great platform for telehealth in

our area of practice. And the therapist will modify your program, see how you're responding, and make adjustments as necessary.

DANIELLE TOLMAN: There's so much in everything that you just said that we can branch off in probably five different topic conversations. First, I'll back up to the evaluation and the history taking. I think one thing that has made physical therapy and neurologic rehabilitation in that umbrella too a little bit more unique in treating patients with vestibular dysfunction is that we have the time to listen.

So a lot of times that initial examination with your therapist, they should take the time to really listen to what's going on and evaluate and hear your story. That's where a lot of patients will sometimes the first time feel very heard by a clinician or a provider working with them. And then in that evaluation, too, you might also get a little bit of an idea of how specialized this provider is if they have different types of technology such as infrared goggles. That let us take a closer look.

Not all great vestibular providers need to have goggles to be great. Let's just say that. But if they are somebody who's highly specializes and sees a significant amount of vestibular patients in their caseload, they're likely to have more tools at their disposal like infrared goggles. So that's definitely a great way to give you an idea of where they specialize in that too. Sorry, I didn't mean to cut you off.

RACHEL WELLONS: Oh, no, I was going to say, I really love how you brought up the aspect of time. So that was one of the reasons I decided to become a physical therapist rather than a physician. Well, I was also squeamish and afraid of blood and needles. So I wanted to be in a profession where I didn't have to deal with that.

But the other two is spending time with patients. A vestibular physical therapist at a minimum should spend an hour on your examination. If I get it done in an hour, I'm moving quickly. I usually will average probably about 70 minutes, 75 minutes. And I do know of some providers who will block off about 90 minutes.

So the exam is going to be quite comprehensive. The first questions my patients usually ask is, are my follow-up sessions going to be as long? And I say, I love you too. But no, usually, the follow-up sessions are about 45 to perhaps 60 minutes.

DANIELLE TOLMAN: And that's a good point on time as well. When people think of physical therapy, they think that they're going to have to dedicate three times a week for an hour each time they go in to dedicate. And it's actually very different when it comes to vestibular rehab where we spend a lot of time on that history.

But you're right, a lot of the magic happens at home with the consistency of these home exercises, not necessarily what you're doing in the clinic, although it is important to have regular scheduled follow-ups with your provider to make sure the dosage is correct, that nothing has changed or evolved in that time. And it's normal to make consistent changes to those programs week to week as things progress in the right direction. So time is very different in the vestibular rehab world.

RACHEL WELLONS: Yes, and so especially if you are someone where you don't live close to a high-quality provider, knowing that you might only have to go in once a week or even every other week-- and now, of course, with telehealth, it really is, can we do an exam over telehealth? We certainly can and do a pretty good job of-- I'm a little old school. I'm in my 40s.

So I do like to get my patients at least an initial evaluation in person. But follow-up via telehealth is so helpful. And I know many of you can't drive. Or it can be challenging. But telehealth is a really great option.

And one of my mantras as a vestibular physical therapist and one of the reasons I really love this area of practice is my job is to give you the tools that you can use to help yourself and to heal yourself. And many people with vestibular dysfunction just feel so out of control because this happened out of nowhere. And they feel very powerless.

And I love that my job is to empower you. My patients aren't getting better because of me. I'm a part of it. And I see myself as the coach. But my patients will only get better as

they're putting in the hard work. They are doing 90% of the effort, and I'm doing about 10%.

ABBIE ROSS: You are speaking our language. Our mantra is empowering you to feel better faster. So I love that. Now what kinds of questions should a patient be prepared to answer in that initial evaluation?

RACHEL WELLONS: So of course, basic questions about their general past medical history, past surgeries, medications. The physical therapist is going to ask you about when your dizziness first started, describing that first episode, how have your symptoms evolved over time. They're going to ask you a lot of questions about your symptoms-- how often they occur, how severe your symptoms are, what tends to make-- what activities make it better, what activities make it worse, just really see a pattern of the symptoms.

Looking into a pattern of the symptoms can be a key in the differential diagnosis. As physical therapists, our utmost goal is to return patients to the things that they need to do and the things that they love to do. So they're asking boring questions about things that your work and things physical capabilities you need to do about your work. But then they'll also ask you fun questions about your hobbies and your interests and your passions. And they really want to-- they will work and plan their activities around getting you back to both of those things, the things you need to do and the things that you love to do.

They will probably ask you questions about your home and about your social support. As many you know as well, vestibular disorders and dizziness can be quite psychologically distressing. So a good vestibular therapist will always ask questions about if you're experiencing feelings of anxiety, feelings of depression. And they will screen for that, for sure.

I have been asking-- I find it funny now. It's-- I mean, it's great that it is now a hot topic in physical therapy. But I have been asking my patients about sleep since about 2006,

2007. Because, let's be honest, if you're sleeping three hours a night, there's no way you're going to be able to heal.

So they will definitely ask about your sleep habits, about your function. And the question that all of us will typically finish our history up is, what are your goals for physical therapy? What are the things that you would like to do after physical therapy?

So there's nothing more the physical therapist likes to hear some really specific things and activities they want to return to because that really gets our creative juices going in terms of how we can customize your intervention to you.

DANIELLE TOLMAN: And I will make the tip for all of you watching and listening out there that come in with things written down and prepared because brain fog is a real thing. Coming in, you might have this whole thing prepared. And as soon as you get in front of your provider, it's almost like a blank page.

So having certain things, important milestones or things that have happened written down can be extremely helpful. Or if you're tracking symptoms and episodes can be helpful. But that history is a huge chunk of it.

And we talked about vestibular testing the other day and what to expect, which is very different for audiologic and vestibular testing with these different types of technologies and pieces of equipment. What can somebody expect for the physical examination with the vestibular rehab?

What will that look? Will it be symptom provoking? Is it going to be something that doesn't provoke any symptoms? Like, what can they expect when they go through a typical bedside eval.

RACHEL WELLONS: That's a great question. So certainly in comparison-- so we will do symptom-provoking tests because we need to figure out what makes you dizzy in order to make you better. What I have heard from my patients is typically in comparison to the audiology testing, ours tends to be a little bit better tolerated. That's not certainly a

knock to the audiology peers, just in some of their protocols and what they're doing and what they need. It just happens to be more symptomatic.

So expect that you may certainly have an increase in your symptoms. But the therapist should give you time to rest, should give you time to let the symptoms settle down. And for the most part, if you drove and if you had the ability to drive into the physical therapy appointment, you should have the ability to drive home as well.

However, if you are concerned, especially the first time, you're not sure what to expect, it is never a bad idea to bring a caregiver or a friend with you just to have that safety net or have Uber or Lyft downloaded on your phone to be able to get home. But that would be certainly in rare cases.

The things that are probably going to be most symptom provoking are going to be different eye movements or activities, especially we'll look at a lot of things turning your head. If you happen to have a diagnosis of BPPV-- that is where some crystals get loose and get stuck in an area they're not supposed to be in-- a positional test is going to be very symptom provoking. It shouldn't be anything more than the dizziness, though, that you experience on a daily basis with that.

So it's not going to be any worse. After we do the eye movements, then we'll probably get you up, look at your balance, look at your walking. Again, a physical therapist will monitor your progress and will monitor how you're doing in terms of your exertion. If you need to sit down and take a rest, they will allow you to do that. Or they might even have the judgment to say, you know what, we've done a lot, we can leave this test for the next day. So they can selectively move tests for another day for your tolerance.

ABBIE ROSS: I like what you said about offering to bring someone or suggest you bring someone because also what we do is educate a lot. And sometimes it can be beneficial to have another person listening to all the things you're hearing. And also from the invisibility standpoint of vestibular disorders, it's good to have someone close to you really understand from a provider's perspective what you're experiencing. Is there a

difference in rehab between what we would classify typically as a peripheral disorder like BPPV versus a central disorder like, let's say, migraine?

RACHEL WELLONS: So this could probably be a topic we talk in great depth and detail for hours at a time. But to bring it down a little bit to a lay audience is, there are similarities, and there are certainly differences. First of all-- and this is not true for every case. But in general, patients with peripheral vestibular dysfunction tend to have a shorter course of physical therapy and tend to have better results from vestibular rehabilitation. Not in every case. But that is the general understanding.

In patients with central diagnoses, the emphasis may be more on what we call habituation. So if a certain movement or activity makes you dizzy, we're going to repeat that activity intentionally to desensitize you. And so essentially, what we're trying to tap into is the brain's incredible ability to remold itself. And that is called neuroplasticity.

Our brain is not static. Once we're born, our brain is constantly developing and remolding itself to different experiences. So you have the power through repeated activity to change how your brain functions I think that's amazing. And that's one of the reasons I love being a vestibular physical therapist or a neurologic physical therapist in general because that's really amazing we can change what our brain do does and change how it responds.

Someone with central dysfunction, especially if they have another diagnosis like stroke or multiple sclerosis, they may have more severe balance impacts or gait impairments. So I may tend to do a little bit more intensive balance retraining or things like that. In someone with a peripheral dysfunction, of course, it depends on the peripheral diagnosis. If you have BPPV, it's going to be canalith repositioning. And that is not done at all for central dysfunction.

If you have a unilateral vestibular hypofunction through a virus like vestibular neuritis, maybe even through Meniere's disease through repeated damage with that, what we're going to do is we're going to give you gaze stabilization exercises. And those exercises also, we're still utilizing the principles of neuroplasticity. In those exercises, what we're

trying to do is, unfortunately, there's nothing your physician or physical therapist can do to change the damage that has occurred in the peripheral vestibular system. It is just going to be that way.

However, we can focus on what we can change. We can change how the nerves in the brain and the vestibular nuclei-- so in a collection of neuron areas in the brain, we can change how they refire and respond to movement. They typically fire at a base rate. And then with damage, they fire slower.

But if we force it to work, we can start getting it to fire faster. And it can fire fast enough to where we have compensated for that loss of function so that you can be completely normal. And it's like you never had this to begin with. And the power, again, is all within you to do that.

DANIELLE TOLMAN: Somebody in the chat had brought up the Cawthorne-Cooksey therapy exercises, which is the foundational basis for all of this.

RACHEL WELLONS: Exactly.

DANIELLE TOLMAN: This came from, I believe, that was 1940s.

RACHEL WELLONS: Yes, it--

DANIELLE TOLMAN: Is that correct?

RACHEL WELLONS: --was 1940s, yes.

DANIELLE TOLMAN: And that's what they found-- the repeated movements and whatnot really started helping people feel better, except they weren't individualized at that point in time. Now since the 1940s, we've come a long way. And like any good vestibular program, it should be very individualized to the patient.

So Cawthorne-Cooksey has an entire range of exercises that they wanted you to do. All of them, a couple of times a day, which is probably very extensive and took a lot of time. Now through our evaluation techniques, we can really pinpoint on those movements

that make you feel most symptomatic and habituate those in a more targeted, less time-consuming approach.

But I love that somebody brought that up. I think that, yes, they do work. They're great. But we've come so far in the research that now we can be more targeted and be more specific with the habituation exercises similar to Cawthorne-Cooksey.

In terms of length of treatment, do we see-- this can be very broad. But do we see a typical length of time in therapy for peripheral, for central disorders?

RACHEL WELLONS: So I think the length of time is certainly highly individualistic. And I wouldn't say I do this many sessions for this patient. But in general, when we talk about a traditional physical therapy episode of care, a patient with a peripheral hypofunction, if they are uncomplicated, pretty straightforward, pretty average hypofunction, I would see that patient for four to six weeks.

So once a week four to six weeks. If they are progressing a little bit quickly, maybe I only see them for about three weeks. If they're progressing a little bit slower or they have a lot of life stuff and they're not doing their exercises as much, maybe it's 10, 12 weeks. But really, by three months, it should be resolved.

A patient with BPPV, that's going to be easy. Unless you have, again, a very complicated or atypical case, which do occur, for sure, BPPV should easily be resolved within a session or two. And I would expect the more atypical or complicated cases to be four to five sessions, perhaps at most. Maybe really, really complicated, six sessions. But that would be on the far end.

DANIELLE TOLMAN: So I'm going to-- I'm going to poke in right there just because we have a very specific question in the chat about this. And I'd love for you to give your take on this. "What would you tell a person who has been undergoing treatment with a vestibular physical therapist for 18 months for BPPV without resolution and symptoms?"

RACHEL WELLONS: I would tell them, most likely what you're dealing with is the wrong diagnosis. So BPPV can be really tricky. And there can be a lot of conditions that mimic

BPPV. And I go by the old saying is doing the same thing and expecting a different result is the definition of insanity.

So to me, if I have-- again, I trust myself. I've been doing canalith repositioning for about 20 years now. So I'm pretty good in this area. If I can't get a patient by the fourth, maybe fifth session at most and they're not responding-- I mean, if my patients progressively getting better, that tells me they're responding. And I might change some subtleties with my strategy.

But if they're really not responding to that, I would advise you to look for a different physical therapist. And I would advise maybe it's BPPV. Maybe it's not. It might be a mimicker. So it might be something different.

ABBIE ROSS: And by the way, I think this is a good place to plug that BPPV treatment is more than just the Epley maneuver. You have different areas in your inner ear that can require different treatments. And then also I think it's good to note that BPPV can recur. So you could be successfully treated for BPPV and then have a recurrence at some point later on. And actually, Dr. Whitney once said, if you live long enough, you're likely to experience BPPV again.

Now if we talk about the flip side here-- so we know that BRT is great in terms of helping to manage symptoms associated with vestibular dysfunction. For the most part, are there any situations where vestibular therapy might not be recommended? And then more specifically, we have a question to piggyback off of that. If you have a diagnosis of vestibular migraine, should you, quote unquote, "get them under control" before starting vestibular therapy?

RACHEL WELLONS: The best patients for vestibular rehabilitation, whether peripheral or central, are ones where I would call-- I would say they have a stable diagnosis. And what I mean-- what do I mean by a stable medical diagnosis?

So a stable diagnosis, I'll use a nonvestibular example. And then I'll use a vestibular example. Something like a stroke or a brain injury, if that happened once and the patient's not bleeding again, they're not getting hit in the head again, if the injury

happened once and then the body can heal itself to gain and improve from the injury-- in the vestibular world, a very stable lesion would be if you happen to have had an acoustic neuroma that was surgically resected. The damage was done at the time of surgery. And then you're going to be on your healing journey from there.

Compare that with an unstable diagnosis. And this is going to be something where the medical pathology and what's going on with the disease process causes a fluctuation in status. So to go with a nonvestibular diagnosis, I would utilize multiple sclerosis. So for those of you who may not know, this is a disease that's characterized by inflammation where the body attacks its myelin. And that's the insulation for the nerves in the brain.

So a patient may be fine for a while. And boom, they get an attack. And some myelin goes down. And then they might heal. And then they get an attack in another area of the brain, et cetera. So they never know what to expect.

A fluctuating disease like that in the vestibular world is Meniere's disease and-- Meniere's disease or vestibular migraine where you're going to have a more unstable presentation. The tricky part as to why vestibular rehabilitation is challenging with an unstable is remember, I talked about that neuroplastic process. We're trying to train the nerves to fire faster.

And so we're trying to train the nerves in light of an injury. So we might train your nerves. And everything's going great. And you're starting to feel better. And then boom, you get hit with something. And it's just like the last four weeks or the six weeks, whatever you just did, just gets erased. And there's nothing more frustrating to the provider and the patient that I put all this time, I put all this effort in, and it was for nothing.

So for that reason, I wouldn't say it's bad to be working with a vestibular therapist. But it might not be as effective until you get the medicine and the medical management to get things stabilized. Once you give a vestibular therapist a stable lesion, watch out. We're going to be off for the races with that.

But until then, it just becomes challenging. However, doing exercises for recovery is not the only tool in a physical therapist or a vestibular therapist toolbox. Education, I think, is so important and so critical. And you guys mentioned earlier that we as physical therapists do have the time to do that and the training for educational strategies.

We also are trained as physical therapists in general. So if you're struggling with balance, we can work on improving balance in other ways. We can also think about giving you equipment, maybe something like a walker or a cane so that you can still get out and do things.

So I wouldn't say, if you don't have medical management, you shouldn't go to see a physical therapist. It's really great to have both of those things in conjunction. Your therapist may make the decision. They may do as much as they can for the time being.

But a good physical therapist will never completely cut you out. They will say, you know what? Let's take a pause here. Let's give the medication or the medical management some time to work. But I want to hear from you in a month. I want to hear from you in two weeks and four weeks and six weeks, whatever it may be. And they'll bring you back in and say, OK, things have changed now. We can maybe try some different strategies.

DANIELLE TOLMAN: I love that you bring up that. We are general physical therapists too. And there are things that we can help with. I think it's worth mentioning too that even with a stable issue, you can still have peaks and valleys along the way of your recovery.

So just because you're having peaks and valleys, good days and bad days doesn't mean that it's not the right time for that. But I think it's also on the physical therapist to recognize when somebody is extremely symptomatic, it's not beneficial to really ramp them up. It's not about filling that every minute of the 45-minute session with some sort of an exercise.

Sometimes if I have patients having really bad days, I still encourage them to come in because we can work on grounding techniques. We can work on more educational resources and identifying triggers and what might have led up to this, how to come back

and what to do when feeling symptomatic in acute episodes to get that to calm down. And that can be as beneficial as going through your vestibular exercises. Now--

RACHEL WELLONS: I almost feel like that's-- so sorry to interrupt, Danielle. But that's really where they almost need us more in those times.

DANIELLE TOLMAN: Oh, absolutely because the last thing we want to do is stop moving and decompensate and lose some of that progress. Just because you have a day where you backslide a little bit doesn't mean you're starting back from square one. It means that you had a little bit of a shift backwards, but we're going to push forward again and regain that loss that we had from that shift backwards.

RACHEL WELLONS: Yeah, and I encourage my patients. Like you said, it's going to be an up-down, up-down. The general trajectory should be improving. And so I always tell my patients, have a long look back. I'm only seeing them once a week or every other week.

So I might see, gosh, I remember you three weeks ago. And you could not have done this exercise. And look, it's challenging today. But you can do it. And we're going to work to make it better. So as a patient going through therapy, I would encourage you to think, how am I today compared with a month ago, two months ago, six months ago? So take those longer look backs and really give yourself grace and give yourself credit for how far you have come and know that this setback is only going to be temporary and that you will continue your path to healing.

ABBIE ROSS: You're still speaking our language. I love it. Now one thing you said a little bit ago is that we as vestibular therapists provide more than just vestibular exercises. You think you're going just for exercises. But you're getting a lot more.

We're talking about stress management. We're talking about what good sleep hygiene looks like. We might bring up dietary changes if we suspect that might be a trigger for you. There are certain things, though, that might involve other disciplines. What other disciplines might we refer to and when?

RACHEL WELLONS: OK, that's a great question. So first, let's talk about the physician providers. I know one of the challenging things for a lot of patients with vestibular dysfunction is there's not just a vestibular doctor and that dizziness can-- while certainly is represented as disorders of the inner ear and the vestibular system, dizziness can also be cardiac issues, medication interactions. Can be so many different things.

So first of all, if I am suspecting something nonvestibular with my patient, I am going to want to refer them back perhaps to their primary care provider to get a good look at their general medical history. If I'm hearing a lot of cardiac symptoms, if someone's telling me about, oh gosh, anything like chest pain or chest heaviness, certainly would refer to a cardiologist. But lightheadedness or faintness or even fainting, I might think about a direct referral to a cardiologist.

Now within the vestibular world, the providers I tend to work with most often are ENT providers, of course, are great at managing the peripheral conditions. I have found-- and this may be very different, depending on your practice area. But even our local neuro-otologists, he does not like to manage vestibular migraine.

So he will defer to a neurologist who's a headache specialist. And this is where your providers will understand the people best in their area. I have a headache specialist here at New Orleans. And she is my favorite provider. And I will-- if I have someone who I'm suspicious of vestibular migraine who's never received that diagnosis, I will for sure refer to her for a definitive medical diagnosis. And she's really the only one I trust in this area in that capacity.

We may also work with general neurologists, of course, if patients are having other neurologic disorders. And a primary care provider may also be good for a patient with vestibular needs if they need a prescription for a SSRI or SNRI. We're not talking about medications directly. But for those patients with PPPD who may need an SSRI, SNRI, primary care is a great first-line provider to reach out to.

As for non-physician providers, I do like to work really closely with our audiologists. I'm very fortunate here at LSU. We have an audiology program that's just two floors up

from me. So if I have a patient and I'm really struggling with their differential diagnosis and I want them to have more in-depth testing, I will refer to our audiologist. And that in-depth testing, again, if I haven't figured out the diagnosis, I'm really throwing spaghetti against a wall in terms of the treatment.

And I would be remiss if I did not mention our psychologist and counselor friends. These disorders can be all consuming. And I love how you guys brought up about the invisibleness of these disorders and having to explain and just being exhausted about it.

And so referring to counselors is very helpful too. Finding a counselor can be challenging, I know, especially post-COVID in light of mental health providers. But one thing that you can really look for-- not every counselor is going to understand vestibular very well. But you can look for a counselor who specializes in counseling for medical disorders or chronic pain. The mechanisms are incredibly similar to disorders for chronic dizziness.

So that's a great place to start. And I've personally found-- when I've worked with counselors in the area, I've found those providers with chronic pain, that they have been incredibly open to learning about vestibular. And they're like, OK, I get what I need to do for CBT and chronic pain.

But fill me in on the vestibular piece. And I've had just about a half-hour conversation on the phone talking about the symptoms and the strategies I've used with my patient and this is what I need. And they're like, great, I got it, thanks for that information. So overwhelming, I have found that counseling providers have been very, very open to that knowledge and collaboration.

DANIELLE TOLMAN: We end up with almost an entire care team. Because a lot of patients with vestibular dysfunction, by the time they do get the help or diagnosis that they needed, they have layers of issues that do all need addressing in different forms. Now somebody going through vestibular therapy, could you describe how they can expect to feel going through their exercises, regardless of if it's peripheral or central?

Just a general feeling of what they should expect in therapy and how they should feel leaving therapy.

RACHEL WELLONS: So this sometimes is not a nice surprise that patients get when they come to me for therapy is, of course, one of the questions I'm going to ask is what movements or activities make you dizzy. And then I'm like, guess what? We get to do those as an exercise.

So unfortunately, that is part of the treatment is where we do need to provoke your symptoms. But we are going to provoke them in a mild amount and in a controlled fashion. So it is tolerable.

My rule of thumb with my patients is on a scale from 0 to 10, 0 being no dizziness, 10 being worst dizziness ever, what is the therapeutic level for provocation is a 3 to a 4. So I will use the terms mild to maybe slightly moderate.

Once you hit a 5 and up, that's when you should stop. That's when you should rest. That's when you should do your grounding techniques, your deep breathing, your meditation. You should get those symptoms calmed down. But then you've got to move again. So a 3 to a 4.

So that is why you really want a vestibular program to be supervised because I am going to gauge that with my patient in the clinic. And I'm going to gauge what activities get them at that level. I'm not going to give them something that's too symptomatic. Conversely, I don't want to give them something that's not provoking symptoms at all because that's just going to waste their time. So it's a really fine balance.

You may have a change in your response to what you felt in the clinic to what you felt at home. It's very important to then contact your therapist and to ask them like, hey, I'm feeling this response. What should I do? The therapist should be able to give you advice to modify that technique at home because, again, they want it to be tolerable.

I will also get the question I feel like I'm a permission granter in life for my patients. And they'll say, Rachel, can I do this? Rachel, can I do that? And I'll say, it depends, how did

you feel? And so for example, they'll say, can I go to the movies? And I'm like, well, let's give it a try, and let's maybe watch a movie at home before you get out to the movie. And where were your symptoms on that 0 to 10?

If they come back and they say, I went to the movies and I was dizzy but it was about a 3, I'll say, great, that was a good therapeutic activity for you. And even though it made you dizzy, I'm proud that you went and did it and you were able to work through it.

If they said, I went to the basketball game and it ramped me up and I was an 8 out of 10, I'm like, you know what, that whole activity is maybe too much for now, let's work towards that in steps, but pace yourself up to that. So that's a really good general thumb. 3 to 4 out of 10 or mild to slightly moderate symptoms.

ABBIE ROSS: Now what you're describing is something we hear so often when we're getting histories and what provokes your symptoms-- visually stimulating environments, whether it's talking, it's a basketball game, it's a busy restaurant, it's the grocery store. Can vestibular rehab help? And more specifically, is there anything about virtual reality helping in these situations?

RACHEL WELLONS: Definitely. So yes, vestibular rehabilitation can be very helpful. The same mechanism that I talked about earlier is that mechanism of habituation where we essentially desensitize ourself by exposure to activity. We can utilize the same concepts and desensitize ourselves to exposure to busy visual stimulation.

The fancy term for that we utilize is called optokinetic stimulation. Again, a very good vestibular physical therapist will find ways to do this in a gradual graded fashion. Thank god for YouTube. Because if there-- there are so many crazy videos on YouTube.

If my patient says-- so I'll give you an example from last summer. One of my patients, she was planning for a trip out to Colorado and to go into the mountains. And again, remember, I said, I'm here in New Orleans. We have no mountains. We have no crazy curves. It's very kind of-- well, I'm not going to say a calm area. It's upbeat than other areas, for sure.

So it's not like I could say, oh, we'll just practice driving around the mountains in a little bit. So we looked up videos. And I typed into YouTube, driving in mountains. And I found all these series of videos of someone driving through the Swiss Alps. And they were beautiful videos.

And so leading up to her trip, she practiced them. And again, she's not going to watch the videos for two hours at a time. She's going to start maybe a few minutes and then work up gradually as her symptoms allow so that when she got to Colorado-- and she either went to Breckenridge or Aspen. She was able to do that drive. And she felt fine.

So breaking it down with videos is going to be a common strategy because it's really safe. Eventually, we'll want to get the patient to real life activity. But we're not going to throw you into the deep end of the pool again.

I'm going to say-- let me give an example. So if a patient is struggling maybe walking through like a store, a crowded store I'm not going to say go on a Saturday morning when it's the most crowded and say, if you can try and go maybe mid-morning or early afternoon when it's less crowded and then work yourself up to gradually reaching that more crowded state.

ABBIE ROSS: There's a term we use called graded exposure. And this is where you become a team with your therapist to discuss what exactly is the right dosage. And then you repeat that dosage until you get better and better with the caveat that some days may be worse than others, of course, just like life in general.

RACHEL WELLONS: Yeah. And, Abbie, I love that you use the term dosage if there's one thing-- I'm going to-- I'll step up on a soapbox for a second because I step up on this with my students all the time. The public, and to be honest, a lot of physical therapists forget that exercise is like medicine. And if we're delivering it for a specific reason, it has a specific dosage.

And your therapist should have a very specific rationale as to why they're giving it to you in that amount. And that is your right as a patient to ask your therapist, why are you having me do this three sets of 10? Why are you having me do this 12 minutes a day?

So the therapist that really should be grounded in evidence-based practice-- and just like the example I use with patients all the time and with my students too is that if you had an infection and you went to a physician and the physician said you need 1,000 milligrams of antibiotic over five days to have this infection heal-- and on day 2, you took 200. On day 3, you took 300. And day 4, you skipped it. And then you got 500 on day 5. And you're not-- and then you go back to the doctor. And you're not better. You know why you're not better.

Exercise is the same way. In order for it to work, we have to hit the proper dosage. Work with your physical therapist to make sure that the dosage-- you can tolerate the dosage, and you can do the dosage. But if you're not doing the exercises at the appropriate dosage, they will not work.

DANIELLE TOLMAN: I will say dosage is, I think, one of the main reasons why some people have bad experiences with vestibular therapy prior to seeing you. They might come in and say, I've tried this before, it was miserable, it made me worse. It's likely that dosage was not the correct dosage. This type of therapy is not no pain, no gain. We're very much trying to stay away from those overstimulating types of environments and situations and gradually working up to being functional and normal again.

I do want to touch a little bit on the neck because we are getting lots of questions about this in the chat. So is the neck or the cervical spine something that you work on routinely with vestibular patients in therapy?

RACHEL WELLONS: Me, personally, no because I am a terrible orthopedic physical therapist. But I recognize that I am a terrible orthopedic physical therapist. And I am so fortunate that I have two orthopedic faculty who also practice in our clinic.

So as a PT, you just need to recognize what you're really great at. And you need to recognize what your limitations are. But I do have the ability to screen the neck to say, ooh, I think the neck is a problem here. And then I will refer to an orthopedic physical therapist to do that.

If my patient comes from a little farther away, I'll work with finding a provider that is closer in their area. I'm really, again, fortunate because I have a lot of former students now. I've been at LSU for 14 years. And so there's a lot of people I'm like, oh, I know they were a good student, they'll take good care of you.

But a physical therapist, yes. Should they be able to do that and should they be looking at that? For sure if they have the skill set to do so.

DANIELLE TOLMAN: And I will say just from general speaking, I am in no way a cervical spine specialist in the orthopedic world of things. But I will notice general tightness and guarding from patients who haven't been moving. I will notice a lot of guarding in the small muscles behind the head that cause a lot of that tension like headaches that come with the stress of being dizzy and guarding.

So very general neck stretches work into a home program, making sure you're clearing any red flags and issues can be helpful and, I think, help a lot of people with especially diagnoses like migraine where they've got a lot of head and neck up symptoms.

RACHEL WELLONS: Yeah, I'll do a few of those general things too, but nothing beyond that.

ABBIE ROSS: Same here. I'm in the same boat as you. Now you mentioned that sometimes you feel like a permission granter. And I totally get what you're saying on that. One of the most common questions I think we get as vestibular therapists that I'm interested to know how you handle-- and it comes from the chat-- is, how do we know when it's safe to drive? A patient says, can I drive again? What are you telling them?

RACHEL WELLONS: So again, you're not going to go and drive on-- we'll see. I'll say I-95 because I grew up in the Northeast here in New Orleans. I would say I-10. You're not going to go drive at I-10 or I 95 at rush hour.

So the first thing is I want to know what symptoms are you dealing with that are keeping you from driving. It's usually a couple of things. Number one, it could be gaze instability.

So if your eyes aren't focusing with head turning, obviously, to drive safely, you need to turn your heads. You need to scan the highway and to be able to focus.

I can do a test of gaze stabilization it's a test called the dynamic visual acuity. So I have an eye chart. Probably a lot of you have done this test. It has five letters in each row. And my eye chart has about 12 rows.

And I'll have the patient's head still. And I'll say, read the letters as far down as you can go. And then I'll get behind them, turn their head at about two turns a second, and then have them do that very same task. So you're looking at the difference between the eyes, the head still, and the head moving.

Normal difference is a two-line difference. So in terms of driving, I'll want my patients to get down to about four or five lines. They don't have to be exactly normal because they're not doing this while they're driving. But I'll want them to be close.

So that is a really good test of gaze stability. Another test for another symptom that can keep people from driving, of course, is visual motion sensitivity. That is a little bit harder to objectively quantify because we don't have the same test.

What we usually focus on is questionnaires or scales or things like that, where you're getting the patient's feelings about it. So I will maybe measure those questionnaires. And I wouldn't say there's a certain cutoff where I'd say, if you're past this, you don't drive; or if you're under it, you drive. But I want them to be able-- I want to feel confident that they're going to be able to handle the busy stimuli coming at them.

Again, return to driving is not going to-- is going to be gradual. And I may say, go out in the middle of the day, just drive in your neighborhood, drive down the block, get that confidence, and go more and more. What I find more often with my patients with vestibular dysfunction is that they tend to be more nervous about driving than-- I think their physical abilities are generally better than they give themselves the credit for. And they often choose to self-restrict more so because driving can be such an anxiety or a fear production.

So for a lot of patients, I'm just like, you need to do it. You need to use your grounding techniques. You need to use your deep breathing. You can take someone with you if you want. I'm OK with that. But to really just encourage them to build on those

DANIELLE TOLMAN: Steps. Just like everything else we've talked about in this last hour, which I cannot believe, again, has gone by so quickly.

RACHEL WELLONS: Always flies by.

DANIELLE TOLMAN: Oh, I feel like we could talk for another hour on a whole bunch of different topics.

RACHEL WELLONS: We really could.

DANIELLE TOLMAN: Well, we're definitely going to have to have you back at some point and share some more of that wisdom of yours because that hour was packed full of amazing information, great tips. And we are so grateful for your expertise this week in closing out our conference. Thank you so much for joining us today.

RACHEL WELLONS: Oh, thank you. I'm very happy to have been here.

ABBIE ROSS: Thank you, Dr. Wellons. And thank you, audience, for joining in the first hour of presentation today. Now we're going to shift gears to the patient panel. We'll bring Heather Davies and Patrick Parkinson back to the show and hand it off to you guys.

But first, I do have a question because you have perhaps unique experiences given your particular diagnoses. Can you talk to us a little bit about your experience with vestibular rehab? Heather, how about you first?

HEATHER DAVIES: I did have a little bit of experience. Because my insurance only covered a few sessions, I really had to take in as much as I could. And thank goodness, my therapist, I guess, took pity on me and gave me the resources and the steps-- and I love the dosing-- to work through on my own, especially, I guess they call it supermarket syndrome as one of my biggest things.

But with what they gave me, I was able to conquer that and those tools. So it just takes persistence and getting a little uncomfortable, you know? But yeah. But I liked what I did, what I was able to participate in.

DANIELLE TOLMAN: Patrick, what about you? Did you go through any sort of vestibular therapy?

PATRICK PARKINSON: I, interestingly enough, did not. And I'm trying to-- during the presentation, I was trying to reflect why I never really did it. And I think that early on, it was actually from a recommendation from my ENT basically saying that vestibular rehab is not for you.

But the more that I've learned about it, I think a lot of it would be applicable. But I think that in my healing journey. I applied a lot of the same principles to myself in terms of graded exposure like when I left work in January of 2022. Basically, healing was all about getting back into these activities once I was able to get things under control without triggering my symptoms.

So I did-- like, I would dose myself with sitting in front of a computer or sitting in front of my phone, digital screens-- that was a big one-- until I could get through a full workday. And I did that with a couple of different activities. And yeah. So applied a lot of the same principles, I think.

DANIELLE TOLMAN: You're definitely along those lines of that unstable condition initially that we had talked about maybe isn't the best time for a vestibular therapy. But later on down the road, when having more chronic symptoms, embracing those principles have certainly seemed to work very well for you. And you have some amazing panelists today that I'm very excited to listen to.

So we will be sure to pass it off to you, guys. I can't believe this is our last day. Happy--

HEATHER DAVIES: I know.

DANIELLE TOLMAN: --Life Rebalanced Live. And I'm really excited for you guys to close this out.

HEATHER DAVIES: Thank you, guys.

PATRICK PARKINSON: Thanks so much, Abbie and-- right.

HEATHER DAVIES: Wow. Hello, guys. Well, for those of you that don't know me, I am Heather Davies. And I am host of the Meniere's Muse Podcast, where vestibular warriors, regardless of their diagnosis, share their journeys. I was diagnosed with Meniere's disease and vestibular migraine in 2016 and 2017. And I'm super excited and a little sad to be having here for the last day of Life Rebalanced.

PATRICK PARKINSON: Thanks, Heather. And for those of you who don't know me, I'm Patrick Parkinson. I've lived with Meniere's disease for just under 20 years. I'm a VeDA ambassador and also the owner of My Meniere's Coach, which provides resources and support to those living with Meniere's as well as other vestibular conditions. And you are more than welcome to learn more or reach me directly at mymenierescoach.com.

Again, yeah, I'll second what Heather said. I've truly enjoyed all the conversation this week and all the questions. I'll continue to do my best to address your questions in this presentation. But without further ado, I think let's go ahead and introduce our final panelists here.

HEATHER DAVIES: Yes, absolutely. Well, let me share a little bit about Christine Moyer. After two years of overwhelming stress, anxiety, and trauma accompanied with chronic ear infections, Christine suddenly became bedridden with debilitating nonvertigo dizziness.

Her medical team deemed her the perfect storm. When she was diagnosed with PPPD in 2022 after seeing 13 doctors and 13 weeks, she understood the need for self-advocacy in finding a proper diagnosis. Through lifestyle changes, faith in God, vestibular rehab therapy, and medication, she was able to slowly regain her stability. Her goal is to spread hope and positivity on her social media platforms while educating about vestibular disorders. You can find Christine on Instagram and TikTok @thatdizzzygirl. And dizzzy is spelled with three Zs for PPPD.

PATRICK PARKINSON: Nice. And I have the pleasure of introducing Geri McNiece. So Geri had motion sickness as a child and struggled with migraine headaches and altitude sickness as she grew into adulthood. In 2000, she began having vertigo, chronic dizziness, vision and sound issues.

Geri discovered hula-hooping in 2007 to be a helpful distraction, which is awesome. And after 22 years of self-treatment, numerous ER trips, tests, and doctor visits, Geri decided that 2023 was the year that she was going to get some real answers. She credits finding VeDA social media as her biggest motivation and inspiration to get help. Exercise, medication, and mindset work are all part of her daily life now.

And surprisingly, her treatment team all agreed that involvement with hula-hooping was also very beneficial, which I love. And now Geri has an exciting new direction for her business, helping other vestibular patients find the joy of movement through hooping. And you can follow Geri on her social media @aRoundJoy.

HEATHER DAVIES: Hello, ladies.

CHRISTINE MOYER: Hello. Hello. How are you?

HEATHER DAVIES: We're so happy to have you guys and excited about this. I'm going to just-- we're just going to jump right in because we only have an hour. And it flies by. But, Geri, can you briefly tell us about your vestibular journey and how you ended up in a vestibular neurological rehab.

GERI MCNIECE: Well, as Patrick said, I had just struggled for years and years. And just, I think in the chat, you see these people like me saying they've muddled through, or they've dealt with it. That's what I did. Ever since 2000, I basically-- the word habituation, I think I self-habituated all those years. And I just did what I could do until after-- I don't know-- how many years is that? 2021, I guess, I started seeing more on social media about it.

And that's what led me to get help. There's more help available. When you don't know anything for all those years and the doctors just keep passing you off as BPPV, do this

therapy once or twice, it just-- I was a revolving door of that and had many MRIs every three or four years just to check is the tumor getting bigger, is there one, or whatever.

And I was just too happy in life because I had-- by 2012 and '14, I was deep into in my hoop business. So I just kept myself distracted when I could. And then seeing more online made me get help.

And I started with a team approach because I had read something, The Dizzy Cook information about how she went to it for more of a team approach. And I just happened to live in Dallas Fort Worth. So I went to UT Southwestern. That way, all the doctors could communicate together.

My primary care physician was like, hallelujah, go get some help. He knew I needed to go for something more specific. But he never pushed me to because I was getting better all the time. I had a passion of what I was doing. And that, I think, is what kept me from perseverating on it, even though for a short time, I would perseverate. But then I would get better and go about my way.

So my doctor with his blessing-- he was like, do it. And it's just been refreshing. And one of the things I did was ask specific questions about, will I be going to physical therapy? Because I want to make sure that I go to someone that is experienced in vestibular conditions.

Now that I know I have BPPV, a little bit left weakness, all those things and my VM and my PPPD-- I think the PPPD was the worst of it. Because all those years, I was fearful of it. And I didn't know. But nobody ever used the word anxiety or anything. They just said, take this medicine, you'll get better. But they didn't address the anxiety in the PPPD.

So getting that piece and asking specific questions about, will I go to somebody who's experienced? And of course, at UT Southwestern, there is somebody that worked with just vestibular patients. And I had to wait to get in with her. But she was excellent.

And listening to the doctor today, the physical therapist, she is just like that. She was wonderful. And when she asked my goals, one of my biggest goals was to just not be

scared to do some of the hoop things that I used to be able to do with less fear. And I think the fear hangs on the longer you do it. And she let me bring my hoop to therapy and made that part of my physical therapy. So that in and of itself was great because it kept me interested.

And so that's what landed me in the world of physical therapy and learning that everything that I had been doing all these years was actually vestibular therapy. And I didn't know it. I didn't know how to explain it. I just felt good. And it made me feel better. Right, so.

HEATHER DAVIES: Well, I can't wait to hear more about that, your story. It's great. It's wonderful. Christine, can you weigh in and tell us a little bit about your vestibular journey and how you ended up in vestibular neurological rehab?

CHRISTINE MOYER: Absolutely. First, Heather, I have to ask, did you write the intro for me? Or did I do that? Because it was phenomenal. You wrote that, right?

HEATHER DAVIES: No.

CHRISTINE MOYER: You didn't?

HEATHER DAVIES: No, you wrote it.

CHRISTINE MOYER: Oh, well, kudos to me because it was phenomenal. It sounded like you're amazing writing because you're a phenomenal writer.

HEATHER DAVIES: Oh, thank you.

CHRISTINE MOYER: So my journey, very similar to what Geri mentioned here. I did the revolving door. I built the team, the neuro, the ENT, the PCP, everybody until I ended up at an ENT that specifically said, we've looked at BPPV, we've treated you for many years, we've treated you VM, none of those things are checking the box, you need to go to vestibular therapy.

And at that point, she referred me to VRT. And it was up to me to find that PT. And reflecting back, again, what Geri mentioned, it is so important to find a PT that is specialized in vestibular rehab therapy. I cannot stress that enough.

Go online. Look at YouTube videos. Know what to expect so that if you go to a PT and they're not matching that, it might not be the right fit for you. And that's what I experienced. I went to a PT. She was phenomenal. She was great. She massaged my neck all the time, which I'm not complaining about.

But that wasn't productive for me. I needed to do the work. And so I knew that that wasn't the right fit. And then I found a VRT that was specialized in vestibular rehab. And she changed the game for me.

PATRICK PARKINSON: Well, wow.

HEATHER DAVIES: What does a typical session look like for you, Christine?

CHRISTINE MOYER: The first 5, 10 minutes we do eval, check in, see how everything's going. Then it's about 45 minutes of putting in the work. And that looks different every day. Walking up and down stairs at the very beginning. Walking in a straight line, just one foot in front of the other.

I mean, at the very beginning, it was very much like a preschool gym class. That's what it felt like. Here, catch this hoop, let me throw you this ball. And then as time went on, it got more intense. And the dosing, as we discussed, increased.

And so I would have to walk the straight line, pivot at the end, catch the ball, throw it back, turn, walk backwards. So it escalated with time as I progressed and improved.

PATRICK PARKINSON: There we go.

HEATHER DAVIES: Were you having symptoms during this time?

CHRISTINE MOYER: During the therapy session?

HEATHER DAVIES: Yeah, yeah.

CHRISTINE MOYER: Oh, yeah. Oh, yeah. Yeah, yeah. So--

HEATHER DAVIES: I think people-- yeah, talk a little on that.

CHRISTINE MOYER: Yeah, you're going to get dizzy. That's the point, right? You got to push that threshold just a little bit more. And that goes back to the dosing of knowing where that threshold is. Not pushing too far, but hitting right at that right line to just push it until you are improving a little bit more each time.

So absolutely, there were times where I was in the middle of therapy session and I was like, hold on. I got to grab the wall here. Give me a minute to put my pieces back together because your girl's a mess. And then I was OK. We can carry on.

But communicating that to my VRT was so important. And just saying you got to give me a second or I need a drink of water just to gather myself and take some deep breaths and then carry on. And I was fine. Yeah. And I usually never left there dizzy. I usually spent the last few minutes decompressing, drinking water, and I drove home.

They mentioned driving. And they said take somebody the first time you go. And I thought to myself, oh my gosh. I didn't even take anybody with me the first time I went. I drove myself. And now that I look back, I'm like, that was kind of scary because I might not have been able to get home.

HEATHER DAVIES: What about you, Geri?

GERI MCNIECE: I totally agree with what she's saying. I went to the same hospital area in Fort Worth for my therapy as I did for some of the testing. And I remember my husband went to all the testing with me because I was scared about getting sick or whatever. Went very prepared.

But then after that, and I saw where it was and I knew how long the drive was. And I felt like, you know what, I'm going to go without you today. He was working. And I feel completely safe that if I feel a little bit dizzy, I'll just sit in the waiting area and compose myself before I drive home. And I didn't have to do it very long at all.

I was a little exhausted because of mostly the brain power that it takes to listen to what they're asking you to do and go OK. It was more mentally for me, a little bit more mentally exhausting. But I'm a little bit older. And it just I had to put the pieces together.

But no, I looked back like she did. I went, you know what, I drove. Wow. OK. But it was because I had a feeling of safety.

And I think over time, and I think Christine will probably agree, now that I'm by myself at home and I'm doing things, every chore that I do, everything in the kitchen, everything outside, I look as my vestibular therapy now. And I know it's OK to dose it. Like if I have a huge mess in my backyard from the storm last night, I'm going to dose that out. And I'm only going to spend five minutes doing a few little of it, come back in, and give myself a pat on the back for getting started and not telling myself I'm too sick to go do that. You know what I mean?

PATRICK PARKINSON: Yeah.

GERI MCNIECE: That's what vestibular therapy taught me. It's OK to dose everything I do, my chores during the day.

PATRICK PARKINSON: Sure, sure. That makes perfect sense. And you mentioned as you're doing these activities, it's about still instilling that feeling of safety as you're dosing, right? And I know that for both of you and both of your stories, at first, you had no clue what was going on. And it took time for someone to actually call out and validate what was going on.

And obviously, you two advocated for yourself. And you found care that worked for you and were able to work through, which I applaud you for. I think that's a recurring theme through the week. But one thing that happened for me and you all may have had a similar experience is that when parts of your symptoms aren't recognized or normalized by your care team, and for me, I'm talking specifically about the link between stress and symptoms and the need to instill that safety.

For me, when I was diagnosed at age 15, I think all of the feelings of stress that I had about the diagnosis since my physician wasn't normalizing those feelings, I buried all of that. And I push it, push it to the back of my mind. And I just kept doing exactly what I was supposed to be doing as a kid, working super hard, good grades, et cetera, all through college and early career. But I had a very combative relationship with my symptoms. It was a grin and bear it type mentality.

GERI MCNIECE: Definitely.

PATRICK PARKINSON: I'm just going to push through. And I did that for years, pushing through meetings, pushing through whatever it was I was doing. And then that led to more issues, right?

GERI MCNIECE: Oh my gosh.

PATRICK PARKINSON: And--

GERI MCNIECE: Yes.

PATRICK PARKINSON: Yeah. So anyways, getting that initial someone to call it out and say no, what you're experiencing is real and these are the messages that you're sending your brain by doing this, so important. So I just wanted to mention that.

CHRISTINE MOYER: There's an expectation I feel like in our culture to grind and to keep going. And if you rest, then you're lazy. And that needs to stop and it needs to change. Because rest is medicine.

And you really have to tell yourself and talk to yourself and say I can't push through this anymore. I need to, I need to lay down. I need to rest. And I'm not going to feel guilty about it. And I'm going to use that as time to recharge and keep going.

Because for me, I didn't, I don't have a choice. I'm a single mom. I work full time. I have to maintain some level of sanity and mental health, which reduces symptoms. And so I really make time for resting. I'm a big fan of the hurkle-durkle, the lie in on the Saturday afternoon.

[LAUGHS]

PATRICK PARKINSON: Absolutely.

CHRISTINE MOYER: So yeah. And as far as the mental health, you're right. Nobody really validated that. And when you said, when you said that, I thought to myself, my VRT has been pushing me to graduate from therapy now probably for five months. And I keep telling her I'm not leaving. I just refuse to leave.

And she's like, you can't be here anymore. Like, you're good. You know how to do it. I mean, she even got a little like curt with me and was like, you can't be here anymore. You need to graduate. You've got all the points needed.

GERI MCNIECE: The point is not to stay.

CHRISTINE MOYER: Right, right. And I'm like no, I'm going to stay because she was the first person to validate my feelings. I just am realizing this now. And she became a security blanket for me.

GERI MCNIECE: Right.

CHRISTINE MOYER: So because of that, I have been like, no, I'm not going to ring that bell, and I'm not leaving. And I'll be back next week. See you then.

[LAUGHS]

PATRICK PARKINSON: Absolutely, absolutely. And everyone is-- I totally agree with what you say. And when it comes to an injury like breaking your arm, everyone's really comfortable saying, hey, you need to rest that arm.

CHRISTINE MOYER: Yeah, yeah.

PATRICK PARKINSON: And then slowly ease back into activities. But there's that stigma around mental health being like other and separate and somehow weak if you have those things. One thing we're seeing in this conference is that there's really no barrier between our mental health and our physical health.

That's kind of an artificial barrier that we've created. The sensitivity of our nerves and our ear, it's all tied to the brain. It's all related. So anyways, Geri, I didn't mean to cut you off.

GERI MCNIECE: No, I was going to say, and for me looking back just sitting here thinking when I would go to my primary care doctor or even the physical therapist that would do the maneuver just for the BPPV, which really wasn't probably what I had, that didn't really seem to help because it kept coming back in weird ways and my vision was changing. But for no one-- all those years, this just shows how much it's important to realize we've come a long way. Nobody ever addressed the anxiety part or the mental health part that was causing me to perseverate on the fact that I'm dizzy all the time.

Like, what's going on? There was no connection by these people. They just kept MRI-ing my brain to make sure I didn't have a tumor.

CHRISTINE MOYER: Right, which just causes anxiety and then you get dizzy.

GERI MCNIECE: And then I get more anxiety about that. And I'm like--

PATRICK PARKINSON: Yeah, yeah.

CHRISTINE MOYER: Yeah. And Dr. Abbie and Dr. Dani, I was just reading over some stuff for them. And they were talking about the dizzy anxiety cycle and how you can get stuck in that loop.

And let me tell you, last week, I was stuck in that loop. And as soon as I saw that picture of that cycle, I was like, I got to get out of this. And immediately, I disconnected from that. And I immediately started feeling better.

GERI MCNIECE: You know what else I do to get out of that? Because it happens to me. And I think Heather will know when I call her, which hasn't been a while, Heather, where I'm just in a loop. And I'm just, the doom spiral is happening. And I'm questioning every symptom I have.

And this is a year down the road where I was doing great a few months ago. But it'll happen. And it's the stress of something else that might bring it on, something I know is coming up. And you know what I do? And it's hard in the winter time when it's cold, and I know a lot of people live in cold environments.

I just go walk. Just walk it off. Just like get outside and walk. And I did it this morning because I wasn't feeling 100%. I never felt 100% when I wake up.

Anybody else? But if I can get up and move for about 5, 10 minutes. Maybe it's with my hoop. Maybe it's just walking. But it takes my brain to another place. And if I can get involved in something that's not using my eyes visually like this stuff, that usually helps take me out of it.

PATRICK PARKINSON: Sure, sure.

CHRISTINE MOYER: I call Heather too.

GERI MCNIECE: Yeah.

PATRICK PARKINSON: It sounds like I need to start calling Heather.

[LAUGHTER]

GERI MCNIECE: Or just text.

HEATHER DAVIES: I need 1-800 number.

PATRICK PARKINSON: Yeah, 1-800 Meniere's Muse support line. So anyways, I want to make sure we're answering--

HEATHER DAVIES: What are you guys--

PATRICK PARKINSON: Go, go ahead.

HEATHER DAVIES: Yeah. I was, no, I'm curious. And I'm sure some of the listeners are too. What are some home exercises that you do? Christine?

GERI MCNIECE: Go.

CHRISTINE MOYER: I use a lot of the physical therapy stuff that I've learned. I'll have my daughter throw a ball back and forth with me. I walk around the house doing the Bowtie Walks. I walk around my neighborhood doing that. I think everybody thinks I'm absolutely insane.

And I'm probably on somebody's Snapchat looking insane. So I do that. But again, Geri was talking about doing everyday activities. If you're outside in the backyard picking up brush or when I do my gardening in the spring, like you're bending down and you're standing up and you're moving your head back and forth, a lot of that stuff it's still stimulating your vestibular system.

I don't have any fancy equipment at home that I use. I do have a squishy pad. I have my sticks. They're everywhere all over my house. You guys know that for VOR.

HEATHER DAVIES: You have a name for those right?

CHRISTINE MOYER: Hmm?

HEATHER DAVIES: You have a name for those, don't you?

CHRISTINE MOYER: They're just pops. Do I have a name for them? I don't know. I don't remember.

HEATHER DAVIES: I forgot what you call them.

CHRISTINE MOYER: My life.

HEATHER DAVIES: I'm glad. I'm glad you have them.

CHRISTINE MOYER: I have them everywhere for VOR, in my bag, just everywhere, my desk. And I just do that, pull it out, and give myself a little VOR now and then. But yeah.

HEATHER DAVIES: What about you, Geri?

GERI MCNIECE: Oh, well, of course, I hoop. I get out and do different things with my hoop. I never really go out in my backyard without it. But there's a lot of challenging things with that.

To me, seem very simple. If you hoop long enough, this is just, it's like breathing, taking that hoop and moving it around my body. But I realize how important it is that I go do it now. And that I look up at my hand while I do it instead of-- this is the thing I want a lot of people to remember and take away today because I was stuck in this for years.

Because they treated me for BPPV, and they said it was my left side. That's where my loss is now too. But I never could-- they told me don't sleep on your left side. So I never did and I still don't. And I know that's bad.

But I do move my head and roll over now in my left a lot more than I used to. And I move my head down, and I look down, and I look up. I wasn't doing that for years. That's why my neck was so stiff. I was so scared to get dizzy that I froze, right?

And it was only in the last year that I learned movement is medicine. You must move to feel your vestibular system. I did not know that. At the age of 63, finally finding that out. Nobody told me that all these years. So I was frozen.

And I remember they said don't look down because the crystals will move or something. So I never looked down. When I gardened, I did this for years. I was just like, and so now, I'm out there just bending over, doing things. And it feels so good to move again and have permission to do it, and know that it's healing your body not hurting it.

PATRICK PARKINSON: Yeah.

GERI MCNIECE: So everything I do in the house, I'm always constantly thinking don't go too fast. Don't dart your eyes too quickly from up to down, especially if you know you're kind of symptomatic that day. I'll just give myself a lot more grace.

But one thing too, there's somebody in the chat the other day was going, it hurts to or they have a problem with looking up and then down into the washer or down into the dryer or the dishwasher. And one thing-- and this is an old hooping trick is I look at the back of my hand. I learned when I was first hooping-- I don't spin fast anymore. I don't spin. That is something, I've lost that feel.

I don't enjoy that. I can do it, but I have to go very slow. But in the beginning, I'm trying to do it like I was being taught. And it would make me dizzy. And I thought, oh, darn. Here's something else I can't do.

And my instructor, she goes, let me give you a tip. When you get dizzy, if you feel that sensation, just sit down for a moment and look at the back of your hand. It's the closest stationary object. And I thought, oh, you're right.

And so I do that a lot even to this day when I'm not hooping. But of course, following your hand when you're doing something with a hoop, following the path down to the waist for example. I do that when I reach into the dryer or reach into the washer. I'll take my hand and I'll watch my hand as it goes into the dryer.

So I track that. And that's one of the things that I think helps me. And I used to do that before I even knew what it was because I'd heard about the hooping back of the hand thing. So I hope that helps somebody.

PATRICK PARKINSON: Yep, definitely.

HEATHER DAVIES: Yeah. It's awesome.

PATRICK PARKINSON: What I love about this conversation is that it's this common theme of action. Getting into action. Getting moving. And I think Geri, you mentioned the freeze, the tendency to freeze.

I think we all go through that stage. And that's a natural reaction to the room spinning around me. Of course, I'm going to freeze. So we all experience that.

And I went through a phase-- when we freeze, especially for me, we get stuck in our head. And I was online. I went through all the different kinds of therapies-- CBT, acceptance and commitment, all these different things. And it was a lot of thinking, a lot of mental, trying to think my way out of the problem. But there was no substitute for actually getting into action and starting to move.

And I needed some baseline information. I needed to make sure that I wasn't-- I needed to get my body and my system at an acceptable level of stress and anxiety and vertigo or dizziness so I could go out and do things. And then I needed some tools to learn how to get back into those activities without reinforcing the fear, obviously. But once I had those, there's just no substitute for getting out there and doing things that you're afraid of.

CHRISTINE MOYER: Yeah. Your first instinct is to stop moving because you feel unsafe and unsteady. But you're giving the dizziness more power when you do that. And so people are always like, where do I start? I'm like, walk to your mailbox.

If you can't do that, walk out your front door, turn around and come back. Moving your body is when you're going to see the strengthening of your vestibular system. Walking outside, there's just no replacement for that. And Heather, I'll be spiraling. And she'll be like, go outside.

And I'll be like, I don't want to. And she'd be like, go outside. Fine. And so I go outside. And even I wrap myself in my blankie, I'll just kind of walk around my back deck or whatever just to walk.

And I always asked her. I'm like, OK, I feel better now. And it's true. There's no replacement for getting up. And I know how scary it is. I know. But there's just no replacement for moving your body.

GERI MCNIECE: That's true.

HEATHER DAVIES: Yeah. I have to share something with you, guys. At the beginning of my journey, and this may sound crazy. But the only thing I wanted to do was help my husband around the house. I wanted to help with laundry. I wanted to help put dishes away.

I wanted to help cook. But I couldn't because the vertigo was so bad. So I set myself little alarms. OK, today, I'm going to get up and I'm going to help for 10 minutes. And then I'm resting for 30 or 40 minutes.

And then I'm going to get up and I'm going to help for another 10 minutes. And gradually, I increase those minutes that I was helping and decrease my rest time. But over time, I was able to be more productive. And I felt I got my confidence back up and my strength back up.

And it just takes those little things of repetition and trying it out. It doesn't have to be big. You don't have to run a marathon. Like Christine said, just go into your front door.

If you have that motivation to do it, just take those baby steps. And if you're doing too much, back off a little bit. And you have to move. And even when I'm in a funk, just to get outside and walk, I don't know what the psychological benefit behind that is, but something happens when I'm just moving, just the action.

CHRISTINE MOYER: Yeah. And if you don't have the motivation, get an accountability buddy. Heather is like, go outside. My mom will be like, you're going out to dinner tonight at a restaurant. You have to leave the house. You can't live like this anymore.

And I'm like, fine, I'll go. And guess what, I'm fine. I'm fine. But I just sometimes need that little get out.

[LAUGHS]

GERI MCNIECE: My husband, after all this time, he understands this because I've educated him on it. And I remember the day sitting down at the VeDA website going, look, there's people like me. Look, read this.

But now that he understands everything, and he knows I need to rest but I also need to get up. Whereas before, he was like, stay in bed. I don't want you falling over. I don't want you, I don't want you making yourself sicker.

And then now, I can go no, I'm sicker when I lay in the bed. Let me get up and do. And then if he knows I've been in the kitchen for say 10 minutes, I don't set alarms but he knows I limit myself.

He goes, have you been in here about 10? You need to go back and lay down now or go sit down and rest. You don't do too much today. So he helps me monitor that because I tend to want to overdo and push through.

HEATHER DAVIES: Yeah.

GERI MCNIECE: But yeah.

PATRICK PARKINSON: Yeah, yeah. One question that comes up on this topic that everyone wants to know is like, OK, getting back in motion. This sounds great so I can get back to doing the things I love. But how long is it going to take?

How long, how are those baby steps going to take? So the question here is specifically on how long did you do VRT for the vestibular rehab. But we can just speak in general about how long. Yeah, Geri, go ahead.

CHRISTINE MOYER: I refused to leave so I'm still there.

GERI MCNIECE: You're still in. So let's see. My diagnosis was a little kind of like hop, skip, and a jump because I had to wait certain times to get in with certain people. And Dr. Beh is outside of Southwestern now. But I did go to him.

But then I still had to go for some more ear testing. And then I went to-- then I knew I was going to go to VRT. He suggested all that. And he goes, did you got your appointment scheduled? I was like yes, but I'm having to wait till April or whatever.

But I went in. And she did her intake and eval. And she was just flabbergasted. She was like you walk fairly good. And I said, well, on a good day yeah. I mean, some days I'm not and I look drunk.

And she goes, I get it. But you compensate really well. And I was like, I feel like I do. And so she goes let's go.

We did like nine weeks. So I did once or twice a week for nine weeks. And she has a full schedule, so it's hard to put in.

I think we got to week 6 and she was like-- I didn't know it at that time. But she is asking me some things and she was telling me this. And then she goes, you're graduated. And I was like, really? And she goes, yeah, you have got all the goods.

And she went on and on about the hooping and what you do. And she watched me. She had all her therapists come around and watch my feet, my movement. And she goes, the way you shift your weight and all the things, you need to go home. And you need to get back to living.

If you have a problem, here's my number. You can text and do all the things within the Southwestern, UT Southwestern portal and all that. She goes, if you need me, come see me. She even checked my crystal thing again. She did that every time, which I didn't have any nystagmus or anything.

But she said you're good to go. So it was like six weeks. And she goes, really, Geri, if you hadn't been doing all the things you were doing as far as just being able to use your head and feet at the same time and move around and not think, you're just in your flow or whatever. She goes, you probably would need a lot more.

And I'm like, awesomesauce. It's like OK. And so that's-- and I still have really bad flares. But I know I have everything I need here at home. I have a hoop. I have all these ball. I have life. I just do my therapy in that now.

PATRICK PARKINSON: Definitely.

CHRISTINE MOYER: I love that she said get back to living because that is so profound. Because we spend so much time perseverating in our heads that her telling you that you need to get back to living, that's just kind of gives me goosebumps. Because that part of it is such a huge step. Like acknowledging OK, I'm going to get back to living. What does that look like?

GERI MCNIECE: And it looks different. I will say, Christine, it looks different now than it did when she said that. I'm older now. And every year I'm getting older. And there's nothing that can take that away.

Age is going to happen. It's what's up here and how you approach that. And so yeah, I got these deficits, but I still can do what I love. I may have to slow down. I may have to not turn anymore.

I may gain a few more pounds because I'm not as active as I used to be. But I haven't stopped moving. Do you know what I mean? I have to give myself a lot of grace for that because for so long, I could keep my weight off and it made me feel good.

Now, I'm kind of a few more pounds. But am I not perseverating on my dizziness? And am I living and am I doing the best I can? Yes I am. So yeah.

CHRISTINE MOYER: Amen.

HEATHER DAVIES: Well, you've come to a level of acceptance. And I think you have to do that. And I think Patrick and I spoke about surrender the other day. And it can be used. Sometimes people think of it as a negative thing.

But once you surrender to the symptoms and accept them, then you can learn how to live through them and with them. Yes, your life's going to look different. It's going to be completely different. But that's OK.

It's just learning to live your best life with these symptoms so you can move forward like your therapist said. And it sounds like you guys both have some kind of acceptance. Christine? Besides not wanting to leave your therapist.

CHRISTINE MOYER: I mean, yes. I think for me, acceptance is a roller coaster. Some days I'm crying because I can't believe I'm here. I can't believe I'm talking to all of you and the opportunities to network with people and my social media stuff and being on the board of VeDA. I can't believe I'm here.

Two years ago, I couldn't get out of bed. And so in those moments, full acceptance. And then Heather, you know last Saturday, I was absolutely spiraling out of control, like just doom spiraling. And there was zero acceptance in that moment.

So I would be lying if I said I fully learned how to accept where I am in my vestibular journey. I have moments where I fully accept where I am, and most of the time I do. But there are moments where I just-- and usually, those moments are where I'm not taking care of myself.

I'm not walking. I'm not sleeping enough. I'm not eating properly. As soon as I let that start to slip, everything else starts to get, and I can't do that.

GERI MCNIECE: I think that's where what you said brought up such a good point. I have my down moments when I realize I got to keep doing all this. Because if I don't do these things, I'm going to get like that, and I'll doom spiral. And it happens to me too.

And that's the exhausting part of it. And it's not hard things. It's just oh my God, I've got to remember I've got to have the hydration ready. I've got to have all these things in a certain spot so my husband can get to them quick for when I need it.

I have to every day make sure that I get enough sleep, which is hard. We all know that. We've talked about it. But here's the thing. If you flip the script, and I think I've talked about this before with you, Heather. I know we've talked about it in group.

Having a vestibular condition while nobody understands it, and we have a hard time explaining it to everybody. If you can just look at it as a blessing because it keeps you on a more healthy path, because if we don't, we'll be really bad. We'll pay the price. Everything gets worse. We have these flares and attacks.

We don't want that. We don't want to be dizzy. We want to not be dizzy. So we have to do healthy things to keep ourselves not dizzy. And a lot of people don't have that to guide them as their North Star.

We do. And I have to remember that's a good thing. Geri, this is good. I want to be here longer. I'm feeling good.

CHRISTINE MOYER: There's also, since being diagnosed and experiencing these symptoms, a level of appreciation that I have for everything, the small things.

GERI MCNIECE: Amen.

CHRISTINE MOYER: Taking my daughter to the movies to see the Taylor Swift Eras concert. That was the first movie I'd been to in two years. I stood there. I danced with her. I had to hold on to the railing a little bit.

But I mean, I'm in there just welling up because I'm getting to experience this with my daughter. Going to the beach and walking in the sand. And even though the water and everything was visually kind of a little triggering, still being there and knowing I left the house, I packed a bag, I got in the car, and I drove that far to go to the beach, I appreciate all of that so much more.

Spending time with my family. I know how precious it all is now. And I know how valuable our health is now and how quickly you can lose it. And so I think the time, just the value of time and appreciation changed so much for me. And I appreciate so many things so much more now.

GERI MCNIECE: Yep.

PATRICK PARKINSON: So, so important. I love how you call it like this general path to well-being, right? And you started on the conversation of acceptance, which I totally agree. We throw that out like well, just accept it.

We are not wired to accept. Every fiber in our body since we were born is wired to not accept it. So it's on a spectrum. It's part of that path. It's part of what we can shoot for.

GERI MCNIECE: I even have gratitude. You know what? I even have gratitude now that I had-- it wasn't as severe with my symptoms about 15 years ago, let's say. And I got to do some things, some really fun things that if those were presented to me now, I could not do.

So it would just be I don't have enough bandwidth in my brain for certain things. And I accept and know that now. And I'm just grateful for the experiences I had. And then I look back and go God knew I needed to do that kind of stuff earlier in life. So yeah.

CHRISTINE MOYER: Yes, yes, so much of that. Yeah.

GERI MCNIECE: Yeah.

HEATHER DAVIES: Do you, guys, have a mindful practice? I know Patrick and I do. I wasn't sure what yours involved if you do have one.

CHRISTINE MOYER: Yeah.

GERI MCNIECE: I have a breathing, I do breathing practice pretty much every day. I like to try to do it probably three times a day. It's a certain kind of breath control breathing. It's derived from yoga but you don't have to be laying on the floor or anything to just loosely put it.

It's more like a water category breathing. There's three different types. I learned this in a course I took. Water breathing is a kind of breath that you do. You can do anything-- it's like water to sustain.

You have to have water to sustain. Whereas another type of breathing would rev you up like a coffee breath. And then the wine or whiskey would be the kind you'd use at night to get you tired, right?

Well, water breathing is just, it's more like I guess some box breathing. But I did learn a lot about vagus nerve and how to really control it with my breath. Kind of close off the back of my throat a bit and still breathe through my nose. It really helps a lot to escalate me down when I'm having a moment. But then if I get in a practice of doing it regularly, then it's just kind of always present.

You're kind of self-soothing your nervous system by yourself. And so that's my one mindful thing that I do. I do a little bit of yoga nidra at night. And then just relaxing, hooping during the day, whatever that looks like.

Could be out in my yard to grab my hoop. Go outside. No music just the birds chirping. And I'm just hooping. Yeah. That's it.

HEATHER DAVIES: Awesome! What about you, Christine?

CHRISTINE MOYER: Yeah. I think I'm a little bit, I'm a little bit laggy. I'm a little bit laggy right now. Sorry. So for me, it's just-- that looked serious.

HEATHER DAVIES: I'm glad you're OK.

CHRISTINE MOYER: You all right?

GERI MCNIECE: I'm fine.

CHRISTINE MOYER: OK. I was thinking you fell off your chair for a second there.

GERI MCNIECE: It was a cup. But it sounded worse than it was. It was empty. So that's OK.

[LAUGHTER]

CHRISTINE MOYER: For me, humor. Humor is huge for me. I know that everybody sees that on my platform. I have to laugh at myself because if I don't, I'll just cry all the time.

So if I fall or say something wildly inappropriate like telling the PE teacher at my daughter's school the other day that I loved him by accident because I meant to say it to my daughter. Stuff like that. When the brain fog hits and just stuff just rambles out of my mouth, I just laugh about it. Because you just really have to laugh.

And I do practice box breathing and EFT tapping. I love meditation definitely. And right now, I'm working on becoming Snow White. So I bought a 3-pound bag of peanuts, Heather.

I bought a 3-pound bag of peanuts from Amazon. And I go outside every morning. And I call the squirrels to my backyard. And they are actually starting to come to my backyard now. And I'm telling you, it's just such, it's just such a wonderful way to start my day in nature with my little squirrel friends.

All of my neighbor's backyards are covered in holes right now. But so far, they don't know where they're coming from. So it's fine. But I love it.

It really just like feels like it grounds me. And I call my little, I know this sounds so silly. But really, it's just made such a huge difference in my morning. I just love it.

GERI MCNIECE: You know what I did this morning because we have had some storms, but it's that time of year where all the rain comes and everything's blooming. And all my things are coming up in my garden. And I'm out there, I was talking to my flowers this morning.

So yeah, I garden. And so that's another thing I do. Now, it's starting right now. So I'm really excited. Yeah.

CHRISTINE MOYER: Just finding the little things that bring you joy. And just really, just sitting in that and taking it all in. I mean, you don't have to be actively sitting on the floor practicing yoga or doing some type of rhythmic breathing. Sometimes it's really just sitting in those moments and taking them in, and just being really present. And you know--

GERI MCNIECE: And intentionally, yeah.

CHRISTINE MOYER: Yes, yes. That's the word I was looking for.

GERI MCNIECE: I'm going to go out today and experience a little joy, whatever that looks like for you. But don't just sit inside. Because I think once you physically go out into the outside, that just takes that roof off, the ceiling off. You may not get very far, but past to the front walkway or whatever. But you're out from that ceiling. And I think that helps, yeah.

CHRISTINE MOYER: I also will say I'm a huge advocate for positive affirmations. I've talked about this. I heard this from a YouTube video from someone who also has PPPD at the very beginning of my journey. And I implemented it immediately.

But not giving the dizziness any power and saying things like I am stable. I am steady. I am healing. I am healthy. And not saying I'm not dizzy.

Because as soon as you give that word power, you've acknowledged it exists. And I can tell you, there is so much power in those words. Because when I'm offline and not doing anything-- and this has nothing to do with screen time. I know that I'm saying these affirmations all the time to myself, and my symptoms decrease.

Now when I go online, on my social media platforms, and I'm responding to people talking about my dizziness, I see an uptick in symptoms. And I just feel like it's from acknowledging that this exists in my brain. And when I'm not acknowledging it, there's a decrease. So really just set, whatever those look like for you, set those affirmations and say them to yourself constantly all day long. And don't give the dizziness any more power over your life than it already has.

GERI MCNIECE: Right. I talk to my brain. That's what I learned. And I learned that from that book. What is it? The Way Out.

I literally did that. I think I told you that, Heather. Remember when I said I grabbed the bookcase and I said, OK, brain, you are lying to me. And I remember focusing on these books because it was like doing like this.

And for me to talk about it is even hard. But I talk to my brain now and I did not do that a year ago. And I tell it no, you're lying. And I said that so many times to myself. But I said it out loud a couple of weeks ago. But yeah.

PATRICK PARKINSON: Yeah, yeah. It's like you can say it, you can deliver these messages of safety via words and affirmations. Or like you were saying, before, it can be by your actions like getting outside and being the Cinderella squirrel queen. Whatever brings you--

CHRISTINE MOYER: Snow White.

HEATHER DAVIES: Snow White.

[LAUGHTER]

CHRISTINE MOYER: Snow White is the one who clean the house. I don't do that.

PATRICK PARKINSON: My wife is going to kill me if she sees this. She's going to yeah.

GERI MCNIECE: I said you're lying brain.

PATRICK PARKINSON: All right. I apologize. I apologize. But I think when you show you can have joy and laugh in the face of your symptoms, that's such a powerful message. Anyways, Heather, I didn't mean to cut you off there. Go ahead.

HEATHER DAVIES: No, no, you were fine. We were just correcting you on which princess Disney.

PATRICK PARKINSON: Yes, yes, I'm aware of that. Yeah, yeah.

HEATHER DAVIES: Just real quickly. I know we're coming in on the end, but do you, guys, go to talk therapy? Do you have therapists? Have you experienced any EMDR or anything like that?

CHRISTINE MOYER: Not EMDR. I do have a therapist. And it's just a traditional therapist that I work with. And I've actually been with her since before my dizziness when I went through my perfect storm of absolute just everything-- breakup, grad school, working, COVID, everything.

And so she's been with me prior to this, which is great. So I have her and then my brain just left the building. Hold that thought.

Hmm, yep, nope. What was I going to say? Therapist. Geri, I'll circle back to that when it comes around.

GERI MCNIECE: Now, I think because my husband and I, we've been empty nesters for a really long time. But we had a lot of therapy as a family because I have a child-- well, both my boys ADHD and autism. But it was way back when there wasn't a lot out there. And so we really had to work it to raise those kids. And we went to a lot of therapy with them.

And some of it was just for me as a mama. And I learned a lot of techniques to take care of myself. And I've really applied a lot more. I think I've told you this, Heather. I treat my PPPD and my VM probably more like a kid, a special needs kid.

And I treat it as such. It's not me, it's that. And I parent it differently. Yeah. So I think I'm OK. I don't go to anybody right now.

HEATHER DAVIES: OK. It was just a question that was brought up in the thing. Well, as we close, I would love for you, guys, to share a little bit of hope. And leave someone-- say you're meeting a newbie for the first time that's experiencing some vestibular symptoms, what would you leave them with today?

GERI MCNIECE: Well, I would say--

HEATHER DAVIES: Geri?

GERI MCNIECE: Yeah. I would say and I truly believe this. I've typed it in the chat. I think there is no better time than now to have a vestibular disorder. Know that there is so much help out there. You just have to reach out and grab it.

Let's start with giving them the VeDA website and explain to them that there are doctors and there are therapists and there are techniques and tools and everything you could possibly want. But you have to go out and grab it. Don't start with your primary care. It's just not the place. And we didn't know that years ago, but now we do.

And there's so much help available. And there's so much support. You just have to go grab it. Get on. And I hate social media on one hand and then I love it for another because it led me here.

So I would say follow x, y, z, some of my favorites. I share those a lot. And just know that there are better days. You can live with this.

You can absolutely live with it and manage it. It looks different for everybody. If you've met one person with a vestibular disorder, you've met one person with a vestibular disorder. So you're unique. And you can get help.

CHRISTINE MOYER: I remembered what I was going to say about the therapy. Yesterday, Lynn, I mean, just unbelievable, unbelievable. She was incredible. And after I heard her speak, and she was discussing the VeDA support groups. She attends the one on Monday.

And immediately, I put it in my calendar. And I was like, I'm going to be going to that one because I saw her, I listened to her, and I was like I need to be in a group with her. Because she was so amazing. So I have not attended a support group because I thought it was going to give me anxiety, if I'm being honest.

I thought it was going to cause me more anxiety. But when I heard her speak and share her feelings and her testimony, and just her faith in herself and in God and everything, I was like yes, sign me up. I'm there. And so I'm going to go to that support group as well as my traditional therapist.

As far as what I would say to someone, find the support, whether it's your family, a support group with VeDA, somebody on social media that you can kind of bounce ideas off of that can help you on your journey. Something I recently just said to myself after a doctor gave me their feedback on my diagnosis was, if you can't tell me off the top of your head with the acronym-- this might be terrible advice by the way. But if you can't tell me off the top of your head what the acronym VeDA stands for, I am not open to your feedback on my diagnosis.

Because I feel like if you don't know what we are here, then you can't speak on it. So that's my new mindset on when anybody likes to comment. Because people love to just throw diagnosis out. Oh, have you done this, have you done that, you have this. And then it freaks me out and I get anxiety. So no more. I'm not doing that anymore.

As far as your journey, be patient with yourself and expect the ups and downs. They are going to happen. And yes, the first few times are the most jarring. But every time gets you a little bit. And just know that those ups and downs are going to happen and it's going to fluctuate.

And please, just be patient with yourself because it's going to go back to baseline. It's just going to take a second and just sit in that for a second and know you're going to get back to baseline. Find your battle buddies. Know you got to ride that cycle. And also I wish that I had started journaling at the very beginning of my journey.

Now, I have video content where I filmed at the beginning. But I wish that I could go back and read a journal. Because I have come so far and I tend to forget that a lot. I went from not being able to leave the house and completely bed bound to being here and talking with you guys.

So the progress is so profound, but sometimes I forget that. So don't forget where you've come and where you are now and know that you're going to improve. You're going to make those improvements and just ride the waves.

HEATHER DAVIES: Yeah, absolutely.

GERI MCNIECE: Small wins.

CHRISTINE MOYER: Yeah.

GERI MCNIECE: Every small win. And if you focus on the processes and the steps and not so much the big destination, things work out. It's just you got to do it slow.

CHRISTINE MOYER: Yep.

PATRICK PARKINSON: Absolutely, absolutely. Such good input. So you both have Instagram accounts. And I think the moderators have dropped it into the chat, so people know how to get in touch with you all. But thank you so much for the discussion. That was, I think, an amazing work you have.

GERI MCNIECE: Thank you.

CHRISTINE MOYER: Thank you. Thank you, guys, so much.

GERI MCNIECE: It's great.

HEATHER DAVIES: Well, thank you to our panelists, Geri and Christina. They were really refreshing and cracking me up. I know. Thank you Cynthia, Elizabeth. Huh?

PATRICK PARKINSON: No, I'm never going to live down the Cinderella comments.

HEATHER DAVIES: You're going to have to learn your princesses.

PATRICK PARKINSON: I got to work that out, yeah. I got some homework to do.

HEATHER DAVIES: Well, thank you, Cynthia, Elizabeth, Tyler, and everyone behind the scenes. We have to mention also that you can get access to the recordings up until our last day. Is that right, Patrick?

And I mean, the attendees-- there you go. There's a website right there. And the attendees can buy lifetime access to watch and rewatch these sessions as many times as you want.

And as a reminder, well, I guess I just started reading that. There's the clip. This is valuable information. And it's presented at the annual event. Remains free to everyone by making a donation to vestibular.org/LRL-donate. These links are also listed in the description below.

PATRICK PARKINSON: Yeah. I'd wanted to provide a final thanks to the James D. and Linda B. Hainlen Discovery Fund, and the University of Minnesota Department of Otolaryngology, and of course, Abbie and Danielle with their amazing physical therapy practice Balancing Act Rehabilitation, and the Academy of Doctors of Audiology for sponsoring this amazing conference.

HEATHER DAVIES: Yes. Thank you, Patrick, for hanging out this week.

PATRICK PARKINSON: Absolutely! I had a blast.

HEATHER DAVIES: Yes. Well, thank you all for joining us this week. Please remember to give yourself grace. Lean on this beautiful community. And share VeDA's resources and make vestibular visible. Bye.

PATRICK PARKINSON: Thanks so much.