b. In standing, trunk rotation with cane behind head, or resisted shoulder flexion and extension;
c. On balance board, shoulder flexion and extension;
d. On trampoline, walk using arm swing.
4. Poor proprioception—Beanbag pass with feet for eight minutes, 3x/week.
5. Poor static balance and control at limits of stability—Progressive static balance training, narrowing base of support (i.e., wide base, narrow base, semi-tandem, tandem). Work on reaching, trunk twisting, head movements, ball throw with patient in one of the positions noted above. The chosen position should be somewhat challenging;
6. Vestibular and cerebellar dysfunction—see Functional Reach Test for suggestions.
7. Ptophobia—Use techniques that increase confidence:
   a. Incorporate reinforcing conversation;
b. Use sensory cues;
c. Reassure visual deficits;
d. Reinforce improvement in other functional skills;
e. Encourage independence with staff and family;
f. Explore fears of previous falls;
g. Break up treatments into smaller and more frequent sessions, if possible;

Rather than covering exercises as they relate to a myriad of balance tests based on input from our readers, we have taken two tests and described how to do them, interpret them, and how to design an exercise program from the results. Unfortunately, we could not do that with all the balance tests that are available. We have provided a template to tie functional tools and exercises together.

Our purpose was to show that there are standard tests used in the clinic and these tests can also be used by physical therapists as exercise experts to design comprehensive exercise programs.

Our hope is that when the two physical therapists who did the studies mentioned at the beginning of the article inquire again, they will get a very different answer. They will hear a resounding roar that therapists are exercise experts, who are using standard tools to design effective exercise programs and are doing their functional best for gait and balance.

References

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