non-parametric and asymmetric, a two-tailed sign test was carried out to evaluate statistical signi cance. Within this the independent variable is the Kinesiotaping and the dependent variable is the reach in each of the three directions.

Results

Participant details are provided in Table 1. All subjects recorded a CAIT score of less than 24/30. Statistical analysis revealed no signi cant di erences between taped and un-taped reach distances in the AM (p=0.210), M (p=0.454) or PM (p=0.077) directions (Table 2). However this di erence was just outside signi cance for the PM direction suggesting a small increase in functional reach when Kinesiotaping was applied to participants with CAI.

Discussion

e results demonstrate that there is no signi cant di erence in reach distance on SEBT, suggesting that the Kinesiotaping procedure had no e ect. is illustrates that the use of Kinesiotape on a chronically unstable ankle has negligible e ect on functional performance in these subjects. is suggests that there is little, if any, bene t in using Kinesiotape as used in this study in treatment or rehabilitation of chronic ankle instability.

Previous studies have demonstrated that taping is one of the most common means of supporting a chronically unstable ankle [18] and has a positive protective and rehabilitating e ect on those with this condition [19-22]. It is, however, bene cial to note that there have been very few studies in previous research looking particularly at the e cacy of Kinesiotape, especially in relation to CAI. is highlights the need for further research, as Kinesiotape is now being used increasingly worldwide, particularly by sports' players.

Even though there are relatively few studies looking into Kinesiotape, the ndings of this study dispute those found by Zajt-Kwiatkowska et al. [23], who stated that the application of Kinesiotape increased the functional capabilities of participants with acute ankle sprain. is could partly explain the di erences as the current study used participants with CAI and in an immediate sense, Kinesiotape may allow a more rapid return to painless movement, though ultimately leading to the same degree of recovery [24]. e present study was, however, consistent with Hendrick [25], who found that it was not possible to determine whether or not Kinesiotape had any e ect on the ankle. It has also been suggested that subjects with chronic ankle instability perceive greater stability, con dence and reassurance when tape is applied to that ankle even if functionally there appears to be little di erence [26,27]. erefore any bene (t a)9(17)47dre appelow loa6(o)1(br f)-636(o)1(b)-9(e)1(lT(k)-9n imm)416(a)](a)l [1(un
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the Kinesiotape to produce its e ect may be of bene t to any further study. elen et al. [24] found an early bene t (within one day) in subjects with shoulder injuries to whom Kinesiotape was applied, rather than within minutes. As Kinesiotape is in some cases regarded as primarily for rehabilitation [25], particularly in dealing with chronic issues such as CAI, which take longer to heal than an acute ankle sprain, further time for e ect could be of bene t.

18. .DUOVVRQ -/ 6ZDUG pDVVRQ *2 7KH HIIHFW RI WDSLQJ RQ DQNOH VWDELOLW\ 3UDFWLFDO LPSOLFDWLRQV 6SRUWV 0HG

&DOODJKDQ 0- 5ROH RI DQNOH WDSLQJ DQG EUDFLQJ LQ WKH DWKOHWH %U - 6SRUWV 0HG

DUULFN - 5HTXD