Tai Chi and Postural Stability in Patients with Parkinson’s Disease

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ABSTRACT

BACKGROUND
Patients with Parkinson’s disease have substantially impaired balance, leading to diminished functional ability and an increased risk of falling. Although exercise is routinely encouraged by health care providers, few programs have been proven effective.

METHODS
We conducted a randomized, controlled trial to determine whether a tailored tai chi program could improve postural control in patients with idiopathic Parkinson’s disease. We randomly assigned 195 patients with stage 1 to 4 disease on the Hoehn and Yahr staging scale (which ranges from 1 to 5, with higher stages indicating more severe disease) to one of three groups: tai chi, resistance training, or stretching. The patients participated in 60-minute exercise sessions twice weekly for 24 weeks. The primary outcomes were changes from baseline in the limits-of-stability test (maximum excursion and directional control; range, 0 to 100%). Secondary outcomes included measures of gait and strength, scores on functional-reach and timed up-and-go tests, motor scores on the Unified Parkinson’s Disease Rating Scale, and number of falls.

RESULTS
The tai chi group performed consistently better than the resistance-training and stretching groups in maximum excursion (between-group difference in the change from baseline, 5.55 percentage points; 95% confidence interval [CI], 1.12 to 9.97; and 11.98 percentage points; 95% CI, 7.21 to 16.74, respectively) and in directional control (10.45 percentage points; 95% CI, 3.89 to 17.00; and 11.38 percentage points; 95% CI, 5.50 to 17.27, respectively). The tai chi group also performed better than the stretching group in all secondary outcomes and outperformed the resistance-training group in stride length and functional reach. Tai chi lowered the incidence of falls as compared with stretching but not as compared with resistance training. The effects of tai chi training were maintained at 3 months after the intervention. No serious adverse events were observed.

CONCLUSIONS
Tai chi training appears to reduce balance impairments in patients with mild-to-moderate Parkinson’s disease, with additional benefits of improved functional capacity and reduced falls. (Funded by the National Institute of Neurological Disorders and Stroke; ClinicalTrials.gov number, NCT00611481.)
Movement impairments, especially loss of the ability to maintain standing balance, adversely affect function and quality of life in patients with Parkinson’s disease.\textsuperscript{1,2} With progression of the disease, patients lose postural stability and have gait dysfunction, difficulty managing activities of daily living, and frequent falls.\textsuperscript{3,4} Although some motor dysfunction, such as tremor, may be alleviated with drug therapy, characteristics such as postural instability are less responsive to medication and require alternative approaches.\textsuperscript{5,6}

Exercise is an integral part of the management of Parkinson’s disease because physical activity has been shown to retard the deterioration of motor functions and to prolong functional independence.\textsuperscript{7-9} Resistance-based exercises that address deficits in balance and strength have shown positive effects.\textsuperscript{10-12} However, they require safety monitoring and are equipment-dependent. Research on alternative forms of exercise that could improve balance, gait, and function in patients with Parkinson’s disease is scarce.

Tai chi, a balance-based exercise, has been shown to improve strength, balance, and physical function and to prevent falls in older adults.\textsuperscript{13-15} Two pilot studies suggest that it may also improve axial symptoms of Parkinson’s disease, such as postural stability.\textsuperscript{16,17} However, there exist few data from large-scale randomized trials that have addressed the efficacy of tai chi in this context.

The primary aim of this study was to examine whether a tailored tai chi program could improve postural stability in patients with Parkinson’s disease. Because the program emphasized rhythmic weight shifting, symmetric foot stepping, and controlled movements near the limits of stability, we hypothesized that tai chi would be more effective in improving postural stability in limits-of-stability tasks than a resistance-based exercise regimen or low-impact stretching (control).

**METHODS**

**STUDY DESIGN**

We designed a randomized clinical trial to compare the effects of exercise at 6 months in a group of patients assigned to tai chi classes with the effects in groups assigned to resistance-training or stretching classes. Each group participated in a 60-minute class that met twice weekly for 24 weeks. An expanded description of the methods is provided in the Supplementary Appendix, available with the full text of this article at NEJM.org. The trial protocol, also available at NEJM.org, was approved by the institutional review board of the Oregon Research Institute, and written informed consent was obtained from all participants. All authors vouch for the completeness and accuracy of the data and attest to the fidelity of the trial to the protocol.

**STUDY PARTICIPANTS**

Study participants were recruited from four Oregon cities (Eugene, Corvallis, Salem, and Portland) by means of newspaper advertisements, referrals from neurologists or physical therapists, and information distributed to local support groups for persons with Parkinson’s disease. Eligibility criteria included a clinical diagnosis of Parkinson’s disease, with a disease severity rating of stage 1 to 4 on the Hoehn and Yahr scale (which ranges from 1 to 5, with higher scores indicating more severe disease)\textsuperscript{18}; an age of 40 to 85 years; at least one score of 2 or more for at least one limb for the tremor, rigidity, postural stability, or bradykinesia items in the motor section of the Unified Parkinson’s Disease Rating Scale (UPDRS) III\textsuperscript{19}; stable medication use; ability to stand unaided and walk with or without an assistive device; medical clearance for participation; and willingness to be assigned to any of the three interventions. Exclusion criteria were current participation in any other behavioral or pharmacologic study or instructor-led exercise program, a Mini–Mental State examination\textsuperscript{10} score lower than 24 (indicating some degree of cognitive impairment), debilitating conditions or vision impairment that would impede full participation in the study, and unavailability during the study period.

**SCREENING AND RANDOMIZATION**

Research staff screened patients by telephone. Those who met prescreening criteria underwent an in-person evaluation and baseline assessment. Eligible participants were randomly assigned to one of the interventions, in a ratio of 1:1:1, without stratification, with the use of permuted-block randomization once eligibility was confirmed and baseline assessments were completed. Outcome assessors were unaware of group assignments.

**EXERCISE INTERVENTIONS**

**Tai Chi**

The protocol consisted of six tai chi movements\textsuperscript{17} integrated into an eight-form routine (see the Supplementary Appendix for more details).\textsuperscript{20,21} Because the goal was to maintain balance through
postural control, the protocol was specifically designed to tax balance and gait by having participants perform symmetric and diagonal movements, such as weight shifting, controlled displacement of the center of mass over the base of support, ankle sways, and anterior–posterior and lateral stepping. The first 10 weeks emphasized the mastery of single forms through multiple repetitions; later weeks focused on repetitions to enhance balance and increase locomotion. Natural breathing was integrated into the training routine.

**Resistance Training**

The protocol, developed from the exercise literature, focused on strengthening the muscles that are important for posture, balance, and gait. Resistance (with weighted vests and ankle weights) was introduced at week 10. Weighted-vest resistance was initially set at 1% of body weight and was increased by approximately 1 to 2% of body weight, depending on each participant’s tolerance, every fifth week until 5% of body weight was achieved. Ankle weights started at 0.45 kg (1 lb) per limb and were gradually increased to 1.36 kg (3 lb). The routine involved 8 to 10 exercises, including forward and side steps, squats, forward and side lunges, and heel and toe raises, performed in 1 to 3 sets of 10 to 15 repetitions. Progression was modified for participants with physical limitations. Natural breathing was emphasized during the training routine.

**Stretching**

This control condition was designed to provide a low-intensity exercise program with the social interaction and enjoyment inherent in the two other interventions but without similar training benefits in lower-extremity weight bearing, strength, or balance. The core activities encompassed a variety of seated and standing stretches involving the upper body (neck, upper back, shoulders, chest, and arms) and lower extremities (quadriceps, hamstrings, calves, and hips), with the use of gentle joint extension and flexion and trunk rotation. Abdominal breathing, with an emphasis on inhaling and exhaling to maximum capacity, and relaxation of major muscles were also included.

**Primary Outcomes**

Primary outcomes consisted of two indicators of postural stability — maximum excursion and directional control — as measured by computerized dynamic posturography (Balance Master System, NeuroCom). Maximum excursion is an assessment of the limits of self-initiated movements as patients shift or lean their center of gravity, without falling, toward the theoretical limit (100%) in each of eight target directions. Directional control, a measure of movement accuracy, is calculated by comparing the amount of movement toward the target with the amount of extraneous movement. Scores on both measures range from 0 to 100%, with higher percentages indicating better balance or control.

**Secondary Outcomes**

Gait (stride length and walking velocity) was quantified with the use of a computerized 4.3-m (14 ft) walkway (GAITRite, CIR Systems). Participants were instructed to walk at their normal pace for four trials; the results were averaged to derive a score for each measure, with higher scores indicating better gait ability. Strength of bilateral knee extensors and flexors was measured at an angular velocity of 60 degrees per second with the use of an isokinetic dynamometer (Biodex System 3, Biodex Medical Systems). Summary peak torque values (in Newton meters [Nm]) of five cycles of maximal extension and flexion were calculated from the average of measurements of both limbs. The functional-reach test assessed the maximal distance a participant could reach forward beyond arm’s length while maintaining a fixed base of support in a standing position, with higher scores indicating better balance. The timed up-and-go test measured the time (in seconds) taken to rise from a chair, walk 3.1 m (10 ft), return, and sit down, with a shorter time indicating better mobility. Participants’ motor symptoms were assessed with the 14-item UPDRS III; scores range from 0 to 56, with lower values indicating less motor disability. Assessors were trained by a board-certified neurologist according to the standard protocol. Interrater reliability was 0.96. Falls were monitored by means of daily “fall calendars” that were maintained by the study participants and collected monthly throughout the intervention or until a participant withdrew from the study.

**Test Procedures**

Outcome measures were assessed at baseline, at 3 and 6 months, and 3 months after completion of the intervention. Participants were instructed to follow their normal schedules for physical activity and medication during the 6-month intervention period. Assessments were conducted during times when participants were in “on” periods...
(i.e., when medication was working and symptoms were controlled). The participants’ antiparkinsonian medications were monitored by means of a self-reported measure.29

**STATISTICAL ANALYSIS**

All primary and secondary analyses were conducted on an intention-to-treat basis. Between-group differences in demographic and baseline variables were tested with a chi-square test for categorical variables and a one-way analysis of variance for continuous variables.

Intervention effects on primary and secondary continuous outcome measures were compared by means of mixed repeated-measures analysis of variance, with and without adjustment for baseline and time-varying covariates (e.g., age, sex, disease stage, health status, medication use and change, and level of physical activity). Pairwise comparisons between the tai chi group and the two other groups were conducted only if the omnibus F-test statistics indicated that the null hypothesis should be rejected. Independent-sample t-tests (with 95% confidence intervals) were used to compare group means. Paired t-tests were used to examine within-group changes from baseline to 6 months. Negative binomial regression was used to model data on falls and to derive incidence-rate ratios (with 95% confidence intervals). The same analytic procedures were used to examine the sustainability of the intervention effects.

We calculated that a sample of 45 participants per group would provide at least 80% power to detect a between-group difference of 6 percentage points in maximum excursion and 10 percentage points in directional control from baseline to 6 months, assuming a 15% attrition rate, at a two-tailed alpha level of 0.05. These predicted percentage-point differences equate to a medium effect size of 0.30 or greater (the difference between two means divided by the pooled standard deviation for the data). For the primary outcomes, a two-tailed alpha level of 0.01 (for four corrected comparisons by the Bonferroni method) was considered to indicate statistical significance. Statistical analyses were performed with the use of SPSS software, version 17 (IBM), and Stata software, version 11 (StataCorp).

**RESULTS**

**BASELINE CHARACTERISTICS OF THE PARTICIPANTS**

From May 2008 through November 2010, a total of 309 persons were screened for eligibility; 195 qualified and underwent randomization (Fig. 1 in the Supplementary Appendix). Table 1 shows the baseline characteristics of the study population. A total of 164 persons (84%) were at stage 2 or higher on the Hoehn and Yahr staging system (range, 1 to 4; median, 2.5). The groups were well matched with regard to baseline characteristics, including age, sex, duration of Parkinson’s disease, Hoehn and Yahr stages, and baseline study outcomes of interest.

A total of 176 participants completed their assigned interventions, and 185 provided complete data on the outcome measures at follow-up. There were no significant differences in the baseline demographic variables or primary outcomes between participants who completed the trial and those who did not. The average attendance across the 24-week period was 37 sessions (77%; 37 of 48 in tai chi; 37 of 48 in resistance training; and 38 of 48 in stretching; median, 39; range, 3 to 48). A total of 137 participants (70%) attended 36 or more sessions (275%). Attendance did not differ significantly among the groups (P = 0.67). There were no significant within-group changes in participants’ outside physical activity (P = 0.23) or use of antiparkinsonian medication (P = 0.16).

**PRIMARY OUTCOMES**

Mean (±SD) between-group differences in outcomes at 6 months are shown in Table 2. The participants in the tai chi group performed significantly better than those in the resistance-training and stretching groups on the primary outcomes. The tai chi group had better performance than the resistance-training group in maximum excursion, with a between-group difference of 5.55 percentage points (95% confidence interval [CI], 1.12 to 9.97; P = 0.01), and in directional control, with a between-group difference of 10.45 percentage points (95% CI, 3.89 to 17.00; P = 0.002). The tai chi group also had significantly better performance than the stretching group in both maximum excursion and directional control, with between-group differenc-
es of 11.98 percentage points (95% CI, 7.21 to 16.74) and 11.38 percentage points (95% CI, 5.50 to 17.27), respectively (P<0.001 for both comparisons). The significant effect of tai chi remained after adjustment for covariates.

From baseline to 24 weeks, the participants in the tai chi group had a mean increase of 9.56 percentage points in maximum excursion and 8.02 percentage points in directional control (P<0.001 for both outcomes). Participants in the resistance-training group had a mean increase of 4.02 percentage points in maximum excursion (P=0.02) but did not have a significant change in directional control (−2.43 percentage points, P=0.35). No significant change from baseline was observed in the stretching group.

**SECONDARY OUTCOMES**

Significant between-group differences were observed after 24 weeks (Table 2). The tai chi group

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### Table 1. Demographic and Clinical Characteristics of the Study Participants at Baseline.*

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Tai Chi (N = 65)</th>
<th>Resistance (N = 65)</th>
<th>Stretching (N = 65)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age — yr</td>
<td>68±9</td>
<td>69±8</td>
<td>69±9</td>
</tr>
<tr>
<td>Female sex — no. (%)</td>
<td>20 (30.8)</td>
<td>27 (41.5)</td>
<td>26 (40.0)</td>
</tr>
<tr>
<td>Body-mass index†</td>
<td>28±5</td>
<td>27±5</td>
<td>27±5</td>
</tr>
<tr>
<td>Hoehn and Yahr stage — no. (%)</td>
<td>9 (13.8)</td>
<td>14 (21.5)</td>
<td>8 (12.3)</td>
</tr>
<tr>
<td>2–2.5</td>
<td>34 (52.3)</td>
<td>27 (41.5)</td>
<td>28 (43.1)</td>
</tr>
<tr>
<td>≥3</td>
<td>22 (33.8)</td>
<td>24 (36.9)</td>
<td>29 (44.6)</td>
</tr>
<tr>
<td>Age at initial diagnosis — yr</td>
<td>61±12</td>
<td>65±9</td>
<td>65±11</td>
</tr>
<tr>
<td>Duration of disease — yr</td>
<td>8±9</td>
<td>8±9</td>
<td>6±5</td>
</tr>
<tr>
<td>Antiparkinsonian medications taken — no.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Levodopa or carbidopa</td>
<td>43</td>
<td>50</td>
<td>50</td>
</tr>
<tr>
<td>Pramipexole or ropinirole</td>
<td>20</td>
<td>21</td>
<td>12</td>
</tr>
<tr>
<td>Other</td>
<td>10</td>
<td>16</td>
<td>20</td>
</tr>
<tr>
<td>Self-reported health status — no. (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poor or fair</td>
<td>35 (53.8)</td>
<td>31 (47.7)</td>
<td>28 (43.1)</td>
</tr>
<tr>
<td>Good</td>
<td>23 (35.4)</td>
<td>28 (43.1)</td>
<td>29 (44.6)</td>
</tr>
<tr>
<td>Very good or excellent</td>
<td>7 (10.8)</td>
<td>6 (9.2)</td>
<td>8 (12.3)</td>
</tr>
<tr>
<td>Score for self-reported habitual physical activity;‡</td>
<td>123±67</td>
<td>107±54</td>
<td>116±62</td>
</tr>
<tr>
<td>Self-reported coexisting chronic conditions — no. (%)§</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>12 (18.5)</td>
<td>9 (13.8)</td>
<td>12 (18.5)</td>
</tr>
<tr>
<td>1</td>
<td>24 (36.9)</td>
<td>17 (26.2)</td>
<td>16 (24.6)</td>
</tr>
<tr>
<td>≥2</td>
<td>29 (44.6)</td>
<td>39 (60.0)</td>
<td>37 (56.9)</td>
</tr>
</tbody>
</table>

* Plus–minus values are means ±SD. The chi-square test was used for categorical variables, and one-way analysis of variance for continuous variables. There were no significant between-group differences in any baseline characteristics. A more detailed listing of baseline characteristics is available in the Supplementary Appendix.

† The body-mass index is the weight in kilograms divided by the square of the height in meters.

‡ Activity was measured by means of the Physical Activity Scale for the Elderly, with scores ranging from 7 to 313 (derived by multiplying activity participation by established item weights). Higher scores indicate higher levels of habitual physical activity.

§ Conditions included arthritis, heart disease, high blood pressure, lung disease, diabetes, osteoporosis, depression, chronic back pain, and cancer; the number of conditions per participant ranged from 0 to 9.
had significantly better performance on the measures of gait and strength, better scores on the functional-reach and timed up-and-go tests, and better UPDRS III scores, as compared with the stretching group (P<0.001 for all comparisons). The tai chi group also outperformed the resistance-training group on stride length and functional reach (P=0.01 for both comparisons).

From baseline to 24 weeks, participants in the tai chi group had mean increases of 10.3 cm in stride length (P<0.001), 10.4 cm per second in walking velocity (P<0.001), 13.9 Nm in knee extension (P=0.001), 5.1 Nm in knee flexion (P=0.01), and 5.0 cm in functional reach, (P<0.001), with decreases of 1.05 seconds on the up-and-go test and 6.42 points in the UPDRS III score (with lower scores indicating improvement). Similar improvements were observed in the resistance-training group: mean increases of 4.3 cm in stride length (P=0.01), 10.0 cm per second in walking velocity (P=0.001), 14.6 Nm in knee extension (P<0.001), 8.9 Nm in knee flexion (P=0.001), and 2.2 cm in functional reach (P=0.007), as well as decreases of 1.00 second on the up-and-go test and 5.07 points in the UPDRS III score (P<0.001 for both comparisons). No significant change from baseline was observed in the stretching group, except for deterioration in walking velocity (a decrease of 4.50 cm per second, P=0.01) and improvement in the UPDRS III scores (a decrease of 1.40 points, P=0.05).

A total of 381 falls in 76 of the 195 participants (39%) were documented during the 6-month study period (Table 3). The incidence rate of falls was lower in the tai chi group (0.22 per participant-month) than in the other two groups. Participants in the tai chi group had 67% fewer falls than those in the stretching group (incidence-rate ratio, 0.33; 95% CI, 0.16 to 0.71). They had marginally fewer falls than the participants in the resistance-train-
No major adverse events were noted (Table 4).

ADVERSE EVENTS

Analyses at the 3-month postintervention follow-up indicated that gains in primary and secondary outcomes in the tai chi group were maintained (Table 2 in the Supplementary Appendix) and that, during tai chi training, indicating the safety and usefulness of this intervention for persons with Parkinson’s disease. Tai chi training also significantly reduced the incidence of falls, as compared with the stretching program. Improvements in primary and secondary outcomes were maintained 3 months after the intervention, a finding that is consistent with prior research involving adults 70 years of age or older. No serious adverse events were observed during tai chi training, indicating the safety and usefulness of this intervention for persons with Parkinson’s disease.

The improvement in maximum excursion with reduced deviation in movement, as shown on the

### Table 2. (Continued.)

<table>
<thead>
<tr>
<th>Measure</th>
<th>Tai Chi (N = 65)</th>
<th>Resistance (N = 65)</th>
<th>Stretching (N = 65)</th>
<th>Between-Group Difference in Mean Change from Baseline†‡</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Tai Chi vs. Resistance (95% CI) P Value Tai Chi vs. Stretching (95% CI) P Value</td>
</tr>
<tr>
<td>Timed up and go (sec)‡‡</td>
<td>8.60±2.90</td>
<td>8.95±2.72</td>
<td>8.69±3.18</td>
<td>−0.05 (−0.55 to 0.46) NS −1.03 (−1.58 to −0.47) &lt;0.001</td>
</tr>
<tr>
<td>Baseline</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 mo</td>
<td>7.55±2.69</td>
<td>7.95±2.60</td>
<td>8.67±3.45</td>
<td>−0.12 (−0.67 to 0.43) NS −1.03 (−1.58 to −0.47) &lt;0.001</td>
</tr>
<tr>
<td>UPDRS III score§§</td>
<td>15.28±5.59</td>
<td>15.32±6.04</td>
<td>15.06±6.17</td>
<td>−1.34 (−3.28 to 0.59) NS −5.02 (−6.90 to −3.13) &lt;0.001</td>
</tr>
<tr>
<td>Baseline</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 mo</td>
<td>8.86±4.12</td>
<td>10.25±4.83</td>
<td>13.66±7.54</td>
<td>−1.48 (−4.08 to 1.12) NS −5.02 (−6.90 to −3.13) &lt;0.001</td>
</tr>
</tbody>
</table>

* Plus–minus values are means ±SD. NS denotes not significant. A more detailed version of the table, including results from the 3-month postintervention follow-up, is available in the Supplementary Appendix.
† Mixed repeated-measures analysis of variance (group by time) with baseline, 3-month, and 6-month values indicated a significant between-group difference across all outcome measures (range, P=0.006 to P<0.001). Analyses were performed on an intention-to-treat basis. Point estimates and estimates falling within the 95% confidence interval were generated from independent t-tests for group differences. (See also Fig. 1 in the Supplementary Appendix.)
‡‡ Maximum excursion was assessed as the farthest distance displaced by the participant’s center of gravity during performance of leaning and reaching tasks. Scores range from 0 to 100%, with higher percentages indicating better balance.
§§ Functional reach was assessed as the maximal distance a participant could reach forward beyond arm’s length while maintaining a fixed base of support in a standing position. Higher scores indicate better balance.
†† Directional control was assessed as the amount of movement toward a target, as compared with extraneous movement (away from the target), defined as the ratio of the amount of intended movement minus the amount of extraneous movement, divided by the amount of intended movement. The composite score of eight directions was used for analyses. Scores range from 0 to 100%, with higher percentages indicating better movement control.
¶ Gait velocity was measured by dividing the distance traveled by the ambulation time. Higher scores indicate greater gait velocity.
‖ Peak torque was measured at an angular velocity of 60 degrees per second. Values are given in Newton meters (Nm). Results were the average of five repetitions of measurements at both limbs, with higher values indicating greater strength.
‡‡‡ Timed up and go was measured as the time taken to rise from a chair, walk 3.1 m (10 ft), return, and sit down. Higher scores indicate better mobility.
§§§ The 14-item motor section of the Unified Parkinson’s Disease Rating Scale (UPDRS) III was scored on a 5-point Likert scale from 0 to 4, with 0 representing no impairment and 4 representing marked impairment. Lower values indicate less motor disability. A change of 5 points or more in the score is considered clinically meaningful.\textsuperscript{11}

** DISCUSSION **

We found that a program of twice-weekly tai chi for 24 weeks, as compared with a resistance-training program or a stretching program, was effective in improving postural stability and other functional outcomes in patients with mild-to-moderate Parkinson’s disease. Tai chi training also significantly reduced the incidence of falls, as compared with the stretching program. Improvements in primary and secondary outcomes were maintained 3 months after the intervention, a finding that is consistent with prior research involving adults 70 years of age or older.\textsuperscript{13} No serious adverse events were observed during tai chi training, indicating the safety and usefulness of this intervention for persons with Parkinson’s disease.
Table 3. Self-Reported Falls during the 6-Month Intervention, According to Group.*

<table>
<thead>
<tr>
<th>Falls</th>
<th>Tai Chi (N = 65)</th>
<th>Resistance (N = 65)</th>
<th>Stretching (N = 65)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total falls‡</td>
<td>62</td>
<td>133</td>
<td>186</td>
</tr>
<tr>
<td>No. of falls — no. of participants (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any</td>
<td>19 (29)</td>
<td>31 (48)</td>
<td>26 (40)</td>
</tr>
<tr>
<td>1</td>
<td>3 (5)</td>
<td>8 (12)</td>
<td>4 (6)</td>
</tr>
<tr>
<td>2</td>
<td>4 (6)</td>
<td>7 (11)</td>
<td>2 (3)</td>
</tr>
<tr>
<td>≥3</td>
<td>12 (18)</td>
<td>16 (25)</td>
<td>20 (31)</td>
</tr>
<tr>
<td>Rate — no./participant-month</td>
<td>0.22</td>
<td>0.51</td>
<td>0.62</td>
</tr>
</tbody>
</table>

* Falls were defined as unintentionally coming to rest on the floor or the ground or falling and hitting objects such as stairs or pieces of furniture.
‡ A significant difference was found in the incidence-rate ratio between the tai chi and stretching groups (P = 0.005); a nonsignificant difference was found between the tai chi and resistance-training groups (P = 0.05).
a stand-alone behavioral intervention designed to improve postural stability and functional ability in people with Parkinson’s disease.

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No potential conflict of interest relevant to this article was reported.

Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

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RE decking forms provided by the authors are available with the full text of this article at NEJM.org.

References


