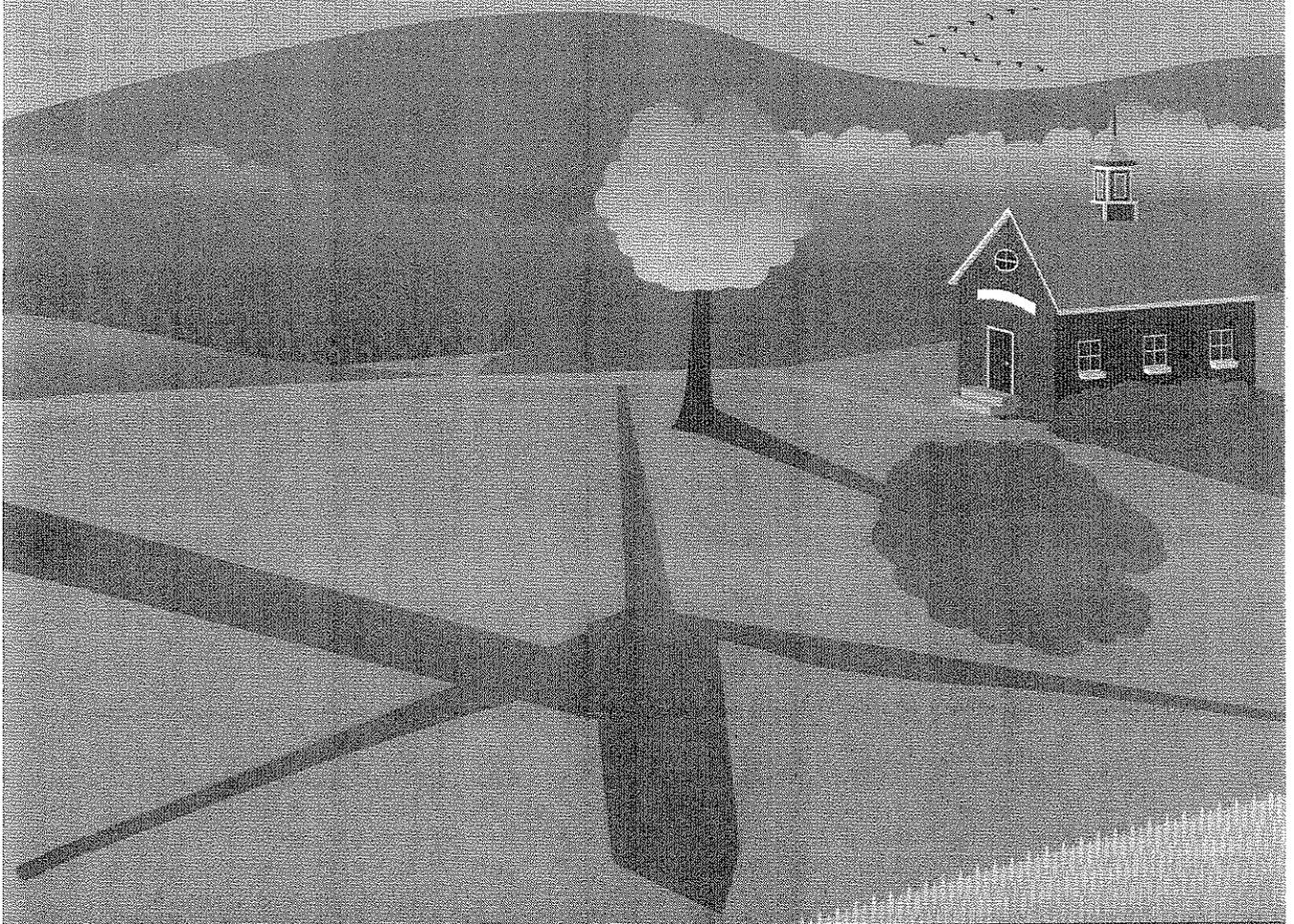


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Wind Turbine Syndrome

A Report on a Natural Experiment

March 7, 2009, pre-publication draft



Nina Pierpont, MD, PhD

March 7, 2009, the following is a pre-publication draft, with
pages missing from WTS for Clinicians & Tables

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A REPORT ON A NATURAL EXPERIMENT

Nina Pierpont, MD, PhD

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PREFACE

I wrote this report because I saw a medical problem which few clinicians were paying attention to or, for that matter, seemed to understand. Dr. Amanda Harry in the United Kingdom led the way in recognizing the cluster of symptoms people experience around wind turbines.¹ I, myself, began encountering the problem from numerous e-mails and telephone calls I received, beginning in 2004, shortly after wind developers turned up in my community and my husband and I began investigating industrial wind turbines.

The uniformity of the complaints quickly became apparent. It didn't take long to realize the potential for a relationship between these complaints, on the one hand, and *migraine, motion sickness, vertigo, noise and visual and gastrointestinal sensitivity, and anxiety* which, all together, form a coherent and interconnected neurologic complex in medical practice.

The breakthrough came in early 2006, when I interviewed a couple who were about to move out of their home because of their own and their children's symptoms. The interview supported the relationship between turbine-associated symptoms and migraine/motion sensitivity. Best of all, the interview introduced me to the curious phenomenon of vibration or pulsation felt in the chest. It was this element that piqued the interest of the National Academy of Sciences in its 2007 report to Congress, *Environmental Impacts of Wind-Energy Projects*. The authors wanted to learn more about this effect of low frequency noise.²

This study is my answer to their question.

As I have worked to understand these complaints, I have benefited from new research allowing us to better understand neurologic phenomena like spatial memory loss and fear reactions in people with balance problems—symptoms that often “bored and baffled” clinicians, as one of my referees put it.³ Some wind developers and acousticians are even less charitable.

¹ Harry, Amanda. February 2007. Wind turbines, noise, and health. 32 pp.
http://www.windturbinenoisehealthhumanrights.com/wtnoise_health_2007_a_barry.pdf

² National Research Council. 2007. *Environmental Impacts of Wind-Energy Projects*. The National Academies Press, Washington, DC. 185 pp, p. 109.

³ I review and discuss this research in the *Discussion* section, pp. xx.

It's ... worth noting that studies have shown that a person's attitude toward a sound—meaning whether it's a “wanted” or “unwanted” sound—depends a great deal on what they think and how they feel about the source of the sound. In other words, if someone has a negative attitude to wind turbines, or is worried about them, this will affect how they feel about the sound. However, if someone has a positive attitude toward wind energy, it's very unlikely that the sounds will bother them at all.⁴

Their patients [the people living near wind turbines and reported on by Dr. Osborne and Dr. Harry] may well have been experiencing adverse symptoms, but we have to keep in mind that people who have failed, for whatever reason, in strong objections to a development, build up in themselves a level of unfulfilled expectations and consequent stress, which peaks after the failure and can overload their coping capabilities. This leads them to lay the blame on whatever straw they can clutch. This is especially so in group activities, where mutual support may turn to a mutual, interacting misery, which worsens the situation. ... The very low levels of low frequency noise and infrasound which occur from wind turbines will not normally cause problems. If problems have occurred, it is possibly for some other stress-related reason.⁵

Brian Howe, a consulting engineer in acoustics for 20 years for HGC Engineering, said Ontario's guidelines for turbine noise are adequate and consistent with Health Canada studies. Most people near wind turbines aren't complaining about the noise, Howe said. In some cases, noise complaints could reflect higher anxiety levels from people who had unrealistic expectations of hearing virtually no sound, he said.⁶

Responses like these are a pity—because they're rubbish. There is nothing “psychosomatic” or malingering about it. Research clearly shows there are precise and definable neurologic connections that explain how sensory signals can derail normal psychological and cognitive function and, in fact, trigger physical symptoms. (It's worth pointing out that our understanding of brain function has progressed by leaps and bounds in the last 25 years, radically changing the landscape of psychology and psychiatry and,

⁴ Noble Environmental Power, LLC. Wind fact sheet #5: Are modern wind turbines noisy? <http://www.noblepower.com/faqs/documents/06-08-23NEP-SoundFromWindTurbines-FSS-G.pdf>, p. 2.

⁵ Leventhall, Geoff. 2004. Notes on low frequency noise from wind turbines with special reference to the Genesis Power Ltd. Proposal near Waiuku, NZ. Prepared for Genesis Power/Hegley Acoustic Consultants, June 4, p. 7.

⁶ Rennie, Gary. 2009. Wind farm noise limits urged. The Windsor (Ontario, Canada) Star. February 24.

of course, neurology.⁷ Much of the research on vestibular function, whereon I draw heavily, is even more recent, conducted within just the last 10-15 years.)

Leaving that bit of pop psychology behind us, let's move on to evidence-based science. In the world of medicine my study is properly called a "case series," defined as *a descriptive account of a series of individuals with the same new medical problem*. Let me be clear: a case series is a standard and valid form of medical research. New illnesses are often introduced with case series, whose role is to define an illness, suggest causation, and alert the medical and research profession to its existence. (This, simply put, is the purpose of this report.) After an illness is defined and awareness raised, it becomes more feasible to do larger, more expensive studies to explore etiology (causation), pathophysiology, and epidemiologic characteristics.

Case series do not typically have control groups. Nevertheless, I saw I needed a comparison group of similar, though unexposed, people to distinguish which symptoms were due to turbine exposure. The most similar unexposed people, of course, were my study subjects themselves prior to turbine exposure and after the end of exposure. I therefore set up a *before-during-after* study format, interviewing families who had already moved out of their homes due to symptoms, or who were planning to move and had already spent periods away from home during which turbine-associated symptoms abated.

This format served a three-fold purpose:

- 1) it ensured there was an "after" phase for each family
- 2) it guaranteed that at least one member of each family was severely affected, enough to need to move, and
- 3) it provided validation for participant statements, since one can hardly discount the gravity of symptoms that force a family to vacate its home or perform expensive renovations aimed solely at noise exclusion.

Which brings us to what is known in science as a "natural experiment." A natural experiment being a *circumstance wherein subjects are exposed to experimental conditions both inadvertently and ecologically (within their own homes and environments)*. Obviously it would be unethical to expose people deliberately to potentially harmful interventions. Hence natural experiments, while less controlled, have an important role in clarifying the impacts of potentially toxic, man-made exposures.

⁷ See, for example, Schore, Allan N., 1994. *Affect Regulation and the Origin of the Self: The Neurobiology of Emotional Development*. Lawrence Erlbaum Associates, Hillsdale, NJ. 700 pp.

The ecological dimension in the phrase *natural experiment* is worth emphasizing, for the simple reason that many elements of an exposure may not be reproducible in a laboratory, such as round-the-clock exposure, exposure over months, or impacts on customary activities. For symptoms related to wind turbine sound, there are also technical difficulties in reproducing in a laboratory the types of sound, air pressure variation, and vibration that my subjects' observations suggest are involved. Failure to provoke the same symptoms in a laboratory setting may tell us more about the limitations of the laboratory situation than about the real-world effects.

To further create comparison groups, I collected information on all members in the ten families, not just the most affected. This widened the age range of subjects and gave me information on variably affected people who were all exposed to turbine noise capable of causing severe symptoms. I then used the natural variation within the study group to examine which elements of the *pre-exposure* medical history predicted which parts of the *during-exposure* symptom complex. By this method, the study begins to answer the intriguing question of why some individuals are affected more than others by living near wind turbines, and which individuals in the general population are at notable risk for symptoms. It also suggests pathophysiologic mechanisms.

It would be difficult to do a conventional epidemiologic study of the health effects of wind turbines, at least in the United States, even if one were blessed with substantial funding and institutional backing, as I was not. By "epidemiologic" I mean studies in which random or regular sampling is used (as, for example, assessing everyone within three miles of a set of turbines, or every fourth name in an alphabetical listing of everyone within three miles) or case and control populations identified. The difficulty comes from the legal and financial stone wall of the *gag clause*.

In the course of this study I repeatedly encountered these clauses in leases between wind developers and landowners, in "good neighbor" contracts between wind developers and neighbors to leaseholders, and in court decisions following citizen challenges to wind turbine development. Gag clauses prohibit people who receive payments from wind companies, or who have lost legal challenges, from saying anything negative about the turbines or developer. The prohibition includes matters of health. In an epidemiologic study based on interviews or questionnaires these clauses could easily distort answers or skew participation, invalidating a random sample.

Some people informed me, as well, that they didn't want to talk about their problems because they hoped to sell their homes in order to flee the turbines next door. (No better way to kill a real estate deal than to leak the news that one's home is toxic.) There is also the matter of relationships and family ties within small communities, where folks are often reluctant to reveal a problem because, let's say, the turbines on your cousin's land happen to be the source of it.

In this manner has the wind industry both shattered many rural communities and thwarted research like mine.

Despite what I see as the virtues of my approach, this study has clear limitations. One being that it was conducted entirely by clinical interview, over the telephone. This had the benefit of allowing me to have an international group of subjects. On the other hand it limited the type of data I could collect. As a result my ability to say that *a certain symptom during exposure is due to turbines* is confined to medical conditions that are diagnosable by medical history—the medical history being *all the information a patient tells the doctor about his illness, his past health and experiences, and habits*.

Non-clinicians should realize that, in medicine, many conditions (ailments) are diagnosed mostly by *medical history*. This includes migraine and other headaches, tinnitus, and sleep disturbance. For, of course, the doctor cannot tell objectively (by any sort of clinical test) if a patient has headache, tinnitus, or sleep disturbance, and much of what the physician figures out about the causes of these symptoms will come from the other questions he (she) asks of the patient. This is the part I could credibly do by telephone.

My study subjects also told me about other kinds of problems that seemed to worsen during exposure—including asthma, pneumonia, pleurisy, stroke, and changes in coagulation or blood sugar. I did not include these problems in Wind Turbine Syndrome, since my method of study did not allow me to determine whether in fact the wind turbines played a role in these conditions during exposure. These conditions would require other kinds of study over and above the clinical interview and case series. (I have included them in a separate section of the *Results* because I think they may need attention from the medical research community.)

This study also does not tell us how many people are affected within a certain distance of wind turbines. But it does offer a framework for what to pursue in such a study (meaning, the next phase: epidemiologic studies), such as what symptoms to study and what aspects of the exposure to measure.

Shifting, now, to the format of the book. I have written it as a (long) scientific article, beginning with an *Abstract* or brief summary, followed by an *Introduction* to the problem and background information, a description of the *Methods* used (including study sample selection), a presentation of the *Results* (which is the data secured during the study and its analysis), and a *Discussion* of the results with interpretation of their meaning in the context of current medical knowledge.

References are footnoted in the text and listed together at the end. I added a *Glossary* of medical and technical terms to make the book more intelligible to non-medical readers, and a list of *Abbreviations*.

There are two sets of *Tables*. The regular *Tables* (numbered 1 A-C, 2, and 3) are compilations of data found in the *Results* section. What I call the *Family Tables* are the raw narrative data of each individual subject's symptoms and statements, organized one person per table with separate columns for *before*, *during*, and *after* exposure and separate lines for each organ or functional system (e.g., sleep, headache, cognition, balance/equilibrium, ears/hearing, etc.).

The *Family Tables* are presented together at the end of the clinical text. They are the backbone, the substance, of my report. I deeply appreciate my subjects' willingness to be included herein.

The book is intended for physicians and other professionals and individuals who wish to better understand the wind turbine-associated symptom complex. This posed a dilemma: writing in the specialized language of clinical medicine and science is very different from the language one uses for lay readers. Yet my goal is to reach both audiences. I solved the problem by adding (at my editor's insistence) a more conversational, parallel text, which I christened *WTS for Non-Clinicians*.

The result is a book with two, tandem texts. They both say the same thing. One says it in the language of the clinician (*WTS for Clinicians*), the other in the everyday language of—well—my editor (*WTS for Non-Clinicians*).

The goal of *WTS for Clinicians* is scientific precision, including frequent expressions of my degree of certainty or uncertainty. Since the physics and the physiology I invoke are complex and not widely known among clinicians, I explain them in this text. Here, likewise, I quote and summarize numerous scientific articles, and I use numbers and statistics (albeit the simplest type known).

WTS for Non-Clinicians says it all over again, this time in English my mother-in-law would understand. To accomplish this I had to sacrifice a degree of scientific precision, since *plain English* and *scientific precision* don't always mix. I freely acknowledge that *WTS for Non-Clinicians* might set some clinicians' teeth on edge. For this I beg their indulgence.

A second disclaimer. Readers should understand that Wind Turbine Syndrome is not the same as Vibroacoustic Disease.⁸ I say this because the two are often equated in the popular media. The proposed mechanisms are different, and the noise amplitudes are probably different as well. Wind Turbine Syndrome, I propose, is mediated by the vestibular system—by disturbed sensory input to eyes, inner ears, and stretch and pressure receptors in a variety of body locations. These feed back neurologically onto a person's sense of position and motion in space, which is in turn connected in multiple ways to brain functions as disparate as spatial memory and anxiety. Several lines of evidence suggest that the amplitude (power or intensity) of low frequency noise and vibration needed to create these effects may be even lower than the auditory threshold at the same low frequencies. Re-stating this, it appears that even low frequency noise or vibration too weak to hear can still stimulate the human vestibular system, opening the door for the symptoms I call Wind Turbine Syndrome. I am happy to report, there is now direct experimental evidence of such vestibular sensitivity in normal humans.⁹

Vibroacoustic Disease, on the other hand, is hypothesized to be caused by direct tissue damage to a variety of organs, creating thickening of supporting structures and other pathological changes.¹⁰ The suspected agent is high amplitude (high power or intensity) low frequency noise. Given my research protocol, described above, my study is of course unable to demonstrate whether wind turbine exposure causes the types of pathologies found in Vibroacoustic Disease, although there are similarities that may be worthy of further clinical investigation, especially with regard to asthma and lower respiratory infections.

Moving on; I have been asked if Wind Turbine Syndrome could be caused by magnetic or electric fields. I have no reason to think so. There has been extensive epidemiologic research since 1979 on magnetic fields and health, comparing people who live close to high power lines or work in electrical utilities or work in other industries where magnetic field exposure is likely to be high, to those who do not.¹¹ This substantial body of research has produced no good evidence that magnetic field exposure causes cancer in

⁸ Castelo Branco NAA, Alves-Pereira M. 2004. Vibroacoustic disease. *Noise Health* 6(23): 3-20.

⁹ Todd NPMc, Rosengren SM, Colebatch JG. 2008. Tuning and sensitivity of the human vestibular system to low-frequency vibration. *Neuroscience Letters* 444: 36-41.

¹⁰ Castelo Branco NAA, Alves-Pereira M. 2004. Vibroacoustic disease. *Noise Health* 6(23): 3-20.

¹¹ Ahlbom IC, Cardis E, Green A, Linet M, Savitz D, Swerdlow A; INCIRP (International Commission for Non-Ionizing Radiation Protection) Standing Committee on Epidemiology. 2001. Review of the epidemiologic literature on EMF and health. *Environ Health Perspect* 109 (Suppl 6): 911-33.

children or adults, cardiac or psychiatric disease, dementia, or multiple sclerosis.^{12,13} After three decades of research, there is still no experimental evidence for a physiologic mechanism for any of the proposed effects of magnetic fields.¹⁴

This makes it very hard to do epidemiologic studies, since researchers don't know what exposure to measure, or what exposure period (e.g., last week or five years ago) might be relevant.¹⁵ An association has been shown between higher magnetic field exposure in utility workers and amyotrophic lateral sclerosis (ALS), a neurodegenerative disease, but this is most likely due to more frequent electric shocks in these settings, not to the magnetic fields.¹⁶ Claims that voltage and frequency irregularities in household alternating currents (what some refer to as "dirty electricity") create a wide, non-specific swath of medical problems – from ADHD to rashes to diabetes to cancer – are completely unsubstantiated, and also have no plausible biologic mechanisms.¹⁷

A few words about peer review. Peer review is quite simple, contrary to the mystique it has acquired among wind developers (most of whom probably have a fanciful idea of what it is). Peer review *consists of sending a scholarly manuscript to experts in that particular field of knowledge, who are asked to judge whether it merits publication.* Simple as that. The identity of reviewers (also called "referees") can be either known to the author (this is often the case with book manuscripts, where authors are routinely asked by the editor to submit a list of possible referees) or kept confidential.

If the referees (usually consisting of two or three) manage to convince the editor that the manuscript is not worthy of publication, the editor contacts the author and rejects the manuscript. If, on the other hand, the referees feel the manuscript merits publication subject to certain revisions and perhaps additions, the editor will forward their reports to the author and ask for a response. "Are you willing to make these changes? Do you agree with these criticisms? If not, give me compelling reasons why not."

The author then revises the manuscript accordingly, except where she feels her referees are wrong—and manages so to convince the editor. Once the editor feels the author has addressed criticisms and suggestions adequately, he (she) proceeds with publication.

¹² Ahlbom IC et al. 2001.

¹³ Johansen C. 2004. Electromagnetic fields and health effects – epidemiologic studies of cancer, diseases of the central nervous system and arrhythmia-related heart disease. Scand J Work Environ Health 30 Suppl 1: 1-30.

¹⁴ Ahlbom IC et al. 2001.

¹⁵ Ahlbom IC et al. 2001.

¹⁶ Johansen C. 2004.

¹⁷ I have asked Prof. Magda Havas, Environmental and Resource Studies, Trent University, Ontario, Canada to remove references to Wind Turbine Syndrome from her PowerPoint presentation on hypothesized wind turbine health effects, because these references are inaccurate.

Lastly, referees do not have to agree with the author's arguments or conclusions. This is worth emphasizing. Their purpose is merely to certify that a) the manuscript conforms to conventional standards of scholarly or clinical research appropriate for the discipline, and, perhaps most important, b) the manuscript is a significant contribution to knowledge.

In the case of this book, a variety of scientists and physicians, all professors at medical schools or university departments of biology, read and commented on the manuscript and recommended it as an important contribution to knowledge and as conforming to the canons of clinical and scientific research. Moreover, they did in fact suggest revisions, even substantial revisions and additions—all of which I made. Some gave me written reports to include in the book itself. Others offered to review the book after it was published.

With that said, the litmus test of scientific validity is not peer review which, after all, is not infallible, as the history of science amply demonstrates. Peer review is an important first step in judging scientific or scholarly merit, however the ultimate test is whether other scientists can follow the author's research protocol and get the same results, or if different lines of research point to the same conclusions.

That, of course, remains to be seen with this report.

I thank Dr. Joel Lehrer in particular for providing me with new information regarding vestibular function, contributions echoed by Drs. Owen Black and Abraham Shulman (all in otolaryngology/neurotology). I thank Professors Ralph Katz (epidemiology) and Henry Horn (ecology) for discussion of scientific method and presentation. Dr. Jerome Haller (neurology) and Professor Robert May (theoretical ecology and epidemiology, past president of the Royal Society of London) read the manuscript and provided commentary to be included in the book, as did Dr. Lehrer and Professors Katz and Horn, for which I am most grateful. Barbara Frey (biomedical librarian) edited the manuscript and provided many essential references.

Other readers read and discussed the manuscript with me and advised on routes of publication. These included Professor Carey Balaban (neuroscience), Dr. Rolf Jacob (psychiatry/ neurotology interface), Dr. John Modlin (pediatrics/infectious diseases), and Dr. Anne Gadowski (pediatrics/public health). I thank them all, as well as Christina Ransom and William McCall, librarians of the Champlain Valley Physician's Hospital in Plattsburgh, NY, and the FYI Hospital Library Circuit Rider Program.

George Kamperman and Rick James, INCE (Institute of Noise Control Engineering) certified noise control engineers, edited the sections describing noise measurement and modeling. They also analyzed noise studies done at the homes of several affected families, while developing standards and protocols for the assessment and control of noise from industrial wind turbines. Kamperman and James presented their standards and rationale at the Noise-Con 2008 meeting of the Institute of Noise Control Engineering (USA) in July 2008, then expanded their paper with a detailed discussion of noise measurement protocols and a model wind turbine ordinance.¹⁸ The expanded paper is posted on the Wind Turbine Syndrome website.¹⁹

Some are surprised that I chose to publish this study as a book rather than an article. My reason is straightforward: it's too long for a medical or scientific journal. The problem is the incompressible yet indispensable narrative data—people's accounts of their sensations, experiences, symptoms, and history. It would be impossible to present these accounts in a 3000 or 7000-word article, yet they are essential as evidence for qualitative changes around turbines.

For example, to support a summary statement like, "The noise from wind turbines has a different and disturbing quality, even when it does not seem loud," I must present the descriptions given by multiple study participants. Likewise, to describe a symptom new to medicine, such as the feeling of internal vibration or pulsation, I again need the words of multiple participants. Because I could not do testing to examine thinking and memory abilities, for example, I need to recount the subjects' own evidence, consisting of their descriptions of things they used to do easily but now cannot do, or of loss and recovery in their children's school functioning.

Many of my reviewers suggested ways to split the study into shorter papers—a segment on migraine, a segment on tinnitus, a segment on methodology, for example. However, I feel that keeping the entire study in one piece makes for a more powerful and intelligible document, allowing readers to appreciate the intertwined nature of individual symptoms and the way they fit with new neural models of vestibular function.

As for the reception I anticipate for this report, I don't flatter myself that it will be greeted with loud hosannas from the wind industry. Keep in mind that wind developers have what is called in science a

¹⁸ Kamperman GW, James RR, Simple guidelines for siting wind turbines to prevent health risks. Noise-Con, July 28-31, 2008, Institute of Noise Control Engineering/USA.

¹⁹ See "How loud is too loud?" www.windturbinesyndrome.com.

“conflict of interest.” Meaning, their judgment is unduly influenced by money. “It’s difficult to get a man to understand something when his salary depends upon his not understanding it,” wryly observed Upton Sinclair.²⁰

I have no conflicts of interest. This research was unfunded, and neither my small village property, my town, nor the Adirondack Park bordering my town is a likely candidate for a wind farm. Is a fondness for bats and other interesting, highly evolved animals a conflict of interest? I wouldn’t think so. Admittedly, I am distressed to hear about bats dying of internal hemorrhage as they fly near wind turbines,²¹ just as I am distressed to hear that people are forced from their homes or endure cognitive impairment of uncertain reversibility in order to remain in the only home they can afford. I have spoken and written earnestly and vigorously about wind developers because of their stubborn refusal to acknowledge health problems amply documented in this and other studies.²² Such stonewalling would test the patience of a saint—and I am no saint.

My hope is that this report will balance the risk-benefit picture of wind turbines more realistically, and help those individuals, such as George Kamperman and Rick James, who are actively promoting noise control criteria that will prevent the health and home abandonment problems documented here.

Kamperman and James have convinced me that a single, one-size-fits-all setback distance may not be both protective and fair in all environments with all types of turbines. Even so, it is clear from this study and others that minimum protective distances need to be:

- a) greater than the 1-1.5 km. (3280-4900 ft. or 0.62-0.93 mi.) at which there were severely affected subjects in this study
- b) greater than the 1.6 km. (5250 ft. or 1 mi.) at which there were affected subjects in Dr. Harry’s UK study
- c) and, in mountainous terrain, greater than the 2-3.5 km. (1.24-2.2 mi.) at which there were symptomatic subjects in Professor Robyn Phipps’s New Zealand study.²³

²⁰ Sinclair, Upton. 1935. *I, Candidate for Governor: And How I Got Licked*.

²¹ Baerwald EF, D’Amours GH, Klug BJ, Barclay RM. 2008. Barotrauma is a significant cause of bat fatalities at wind turbines. *Curr Biol* 18(16): R695-6. Due to air pressure shifts near moving turbine blades, blood vessels in bats’ lungs and abdomen are disrupted, which produces fatal internal hemorrhage.

²² In anticipation of wind industry blowback, I imagine it may once again publicize that it thinks *I think* wind turbines cause mad cow disease. I do not and never did. My reply to this canard – now a family joke – was published several years ago (www.windturbinesyndrome.com/?p=84). My previous reports and papers on Wind Turbine Syndrome and the wind industry can be found on www.windturbinesyndrome.com.

²³ See *Introduction*, p. x, for discussion and references.

Two kilometers, or 1.24 miles, remains the baseline, shortest setback from residences (and hospitals, schools, nursing homes, etc.) that communities should consider. In mountainous terrain, 2 miles (3.2 km) is probably a better guideline. Setbacks may well need to be longer than these minima, as guided by the noise criteria developed by Kamperman and James.

The shorter setbacks currently in use in the USA and elsewhere—1000 to 1500 ft. (305-457 m.)—are a convenience and financial advantage for wind developers and participating landowners. They have no basis in research on safety and health, and they do not make clinical sense.

For those who read this report and recognize their own symptoms, the appropriate medical specialist to consult would be a neurotologist (or otoneurologist), who is an otolaryngologist (ears, nose, and throat doctor) who specializes in balance, the inner ear, and its neurological connections. When I sent this report out for critical review, these were the physicians who recognized a remarkably similar symptom complex from cases familiar to them—such as certain inner ear pathologies.

To those of you living near turbines and recognizing your own symptoms within these pages: you are not crazy and not fabricating them. Your symptoms are clinically valid—and unnecessary. While wind developers rush headlong into yet more projects, you unfortunates will have to exercise patience as the medical profession catches up with what is ailing you. Meanwhile, my advice is: speak out. In *The Tyranny of Noise*, Robert Alex Baron calls for an end to “our passive acceptance of industry's acoustic waste products.”²⁴

This will happen only when the suffering refuse to be silenced.

By the time I finished interviewing (February 2008) and moved on to data analysis, six of the ten families in this study had moved out of their homes because of turbine-associated symptoms. Three months later (May 2008), when the first draft was complete and I contacted the families for their approval and permission to publish the information about them, two more had moved out because of their turbine-associated symptoms—bringing the total to eight of the ten. The ninth family could not afford to move, but had done extensive renovations in an effort to keep the noise out. (Renovations, ironically, that made the house worse to live in, since they could no longer heat it properly.) As of this writing, family number ten is struggling to remain in their home.

²⁴ Baron, Robert Alex. 1970. *The Tyranny of Noise: The World's Most Prevalent Pollution, Who Causes It, How It's Hurting You, and How to Fight It*. St. Martin's Press, New York, p. 12.

Behold ten families whose lives have been turned upside down because of the wind industry's acoustic waste products.

Finally, ask yourself why a country doctor practicing in the poorest county in New York State did this study, and not the Centers for Disease Control or some other relevant government agency. It's a fair question and a troubling one. I ask it myself.

It is well known that wind developers target impoverished communities for their wind farms. This explains the "poorest county" part of my question, and likewise why wind turbines quickly became a looming issue in my life four years ago. But it leaves unanswered the part about, Why did I write this report, and not the government?

To answer that would of necessity catapult this report (and me) into the treacherous territory of public policy. One would like to think science is not beholden (craven?) to public policy, but that would be naïve, would it not? Moreover, while the scientist in me would like to imagine that I can write this report and remain above the hurly burly of public policy, I know this, too, is naïve. Wind Turbine Syndrome is an industrial plague. It is man-made and easily fixed. Proper setbacks are the best cure I know of; they do the job just fine. If I could scrawl this on a prescription pad and hand it to my subjects in this report, I would do so. No brilliant scientist needs to discover a new antibiotic or vaccine or sleeping pill to treat it.

Setbacks, however, are not considered matters of public health, but matters of public policy—what is called "politics." And right there is the rub. In the global rush to wind energy there is almost no voice heard for public health repercussions. Where it is heard—at town meetings, on the Internet, in Letters to the Editor, in courtrooms—it is routinely ridiculed. I speak from experience.

Wind energy is being promoted by every state and national government I know of, under intense pressure (lobbying) by wind development companies generally owned or otherwise capitalized by powerful investment banks which in turn take large tax write-offs and reap large government subsidies for their wind farm projects. These companies then turn around and sell carbon credits (green credits). Perhaps this helps explain why no provision is made for clinical caution?

And perhaps this goes some way toward explaining why a pediatrician in rural NYS and a general practitioner in Cornwall, England—along with a handful of rank-and-file physicians elsewhere in the UK and Australia and who knows where else—are the ones funding this research and writing these reports.

Then so be it.

Nina Pierpont, MD, PhD

Malone, NY

Winter 2009

Draft

Wind Turbine Syndrome for Clinicians

As you read, note that there are missing pages in this typescript ms.

Abstract

This report documents a consistent and often debilitating complex of symptoms experienced by adults and children while living near large industrial wind turbines (1.5-3 MW). It examines patterns of individual susceptibility and proposes pathophysiologic mechanisms. Symptoms include sleep disturbance, headache, tinnitus, ear pressure, dizziness, vertigo, nausea, visual blurring, tachycardia, irritability, problems with concentration and memory, and panic episodes associated with sensations of internal pulsation or quivering that arise while awake or asleep.

The study is a case series of 10 affected families, with 38 members age <1 to 75, living 305 m to 1.5 km (1000 to 4900 ft) from wind turbines erected since 2004. All competent and available adults and older teens completed a detailed clinical interview about their own and their children's symptoms, sensations, and medical conditions (a) before turbines were erected near their homes, (b) while living near operating turbines, and (c) after leaving their homes or spending a prolonged period away.

Statistically significant risk factors for symptoms during exposure include pre-existing migraine disorder, motion sensitivity, or inner ear damage (pre-existing tinnitus, hearing loss, or industrial noise exposure). Symptoms are not statistically associated with pre-existing anxiety or other mental health disorders. The symptom complex resembles syndromes caused by vestibular dysfunction. People without known risk factors are also affected.

The proposed pathophysiology posits disturbance to balance and position sense when low frequency noise or vibration stimulates receptors for the balance system (vestibular, somatosensory, or visceral sensory, as well as visual stimulation from moving shadows) in a discordant fashion. Vestibular neural signals are known to affect a variety of brain areas and functions, including spatial awareness, spatial memory, spatial problem-solving, fear, anxiety, autonomic functions, and aversive learning, providing a robust neural framework for the symptom associations in Wind Turbine Syndrome. Further research is needed to prove causes and physiologic mechanisms, establish prevalence, and to explore effects in special populations, including children. This and other studies suggest that safe setbacks will be at least 2 km (1.24 mi), and will be longer for larger turbines and in more varied topography.

Introduction and background

Policy initiatives in the United States and abroad currently encourage the construction of extremely large wind-powered electric generation plants (wind turbines) in rural areas. In its current format, wind electric generation is a variably regulated, multi-billion dollar a year industry. Wind turbines are now commonly placed close to homes. Usual setbacks in New York State, for example, are 305-457 m (1000-1500 ft) from houses.¹ Developer statements and preconstruction modeling lead communities to believe that disturbances from noise and vibration will be negligible or nonexistent.^{2,3,4} Developers assure prospective communities that turbines are no louder than a refrigerator, a library reading room, or the rustling of tree leaves which, they say, easily obscures turbine noise.⁵

Despite these assurances, some people experience significant symptoms after wind turbines are placed in operation near their homes. The purpose of this study is to establish a case definition for the consistent, frequently debilitating, set of symptoms experienced by people while living near wind turbine installations, and to place this symptom complex within the context of known pathophysiology. A case definition is needed to allow studies of causation, epidemiology, and outcomes to go forward, and to establish adequate community controls.

¹ Town of Ellenburg, NY wind law—1000 ft (305 m); Town of Clinton, NY wind law—1200 ft (366 m); Town of Martinsburg, NY wind law—1500 ft (457 m). For other examples in and outside NY State, see *Wind Energy Development: A Guide for Local Authorities in New York*, New York State Energy Research and Development Authority, October 2002, p. 27. <http://text.nysreda.org/programs/pdfs/windguide.pdf>

² "The GE 1.5 MW wind turbine, which is in use in Fenner, New York, is generally no louder than 50 decibels (dBA) at a distance of 1,000 feet (the closest we would propose siting a turbine to a residence). Governmental and scientific agencies have described 50 dBA as being equivalent to a 'quiet room.' Please keep in mind that these turbines only turn when the wind blows, and the sound of the wind itself is often louder than 50 dBA. Our own experience, and that of many others who live near or have visited the Fenner windfarm, is that the turbines can only be heard when it is otherwise dead quiet, and even then it is very faint, especially at a distance." Letter from Noble Environmental Power, LLC, to residents of Churubusco (Town of Clinton), New York, 7/31/2005.

³ "Virtually everything with moving parts will make some sound, and wind turbines are no exception. However, well-designed wind turbines are generally quiet in operation, and compared to the noise of road traffic, trains, aircraft, and construction activities, to name but a few, the noise from wind turbines is very low... Today, an operating wind farm at a distance of 750 to 1,000 feet is no noisier than a kitchen refrigerator or a moderately quiet room." *Facts about wind energy and noise*. American Wind Energy Association, August 2008, p. 2. http://www.awea.org/pubs/factsheets/WE_Noise.pdf

⁴ "In general, wind plants are not noisy, and wind is a good neighbor. Complaints about noise from wind projects are rare, and can usually be satisfactorily resolved." *Facts about wind energy and noise*. American Wind Energy Association, August 2008, p. 4. http://www.awea.org/pubs/factsheets/WE_Noise.pdf

⁵ "Outside the nearest houses, which are at least 300 metres away, and more often further, the sound of a wind turbine generating electricity is likely to be about the same level as noise from a flowing stream about 50-100 metres away or the noise of leaves rustling in a gentle breeze. This is similar to the sound level inside a typical living room with a gas fire switched on, or the reading room of a library or in an unoccupied, quiet, air-conditioned office... Even when the wind speed increases, it is difficult to detect any increase in turbine sound above the increase in normal background sound, such as the noise the wind itself makes and the rustling of trees." *Noise from wind turbines: the facts*. British Wind Energy Association, August 2008. <http://www.bwea.com/ref/noise.html>

This set of symptoms stands out in the context of noise control practice. George Kamperman, P.E., INCE Bd. Cert., past member of the acoustics firm Bolt, Beranek and Newman (USA), wrote, "After the first day of digging into the wind turbine noise impact problems in different countries, it became clear that people living within about two miles from 'wind farms' all had similar complaints and health problems. I have never seen this type of phenomenon [in] over fifty plus years of consulting on industrial noise problems. The magnitude of the impact is far above anything I have seen before at such relatively low sound levels. I can see the devastating health impact from wind turbine noise but I can only comment on the physical noise exposure. From my viewpoint we desperately need noise exposure level criteria."⁶

I named this complex of symptoms "Wind Turbine Syndrome" in a preliminary fashion in testimony before the Energy Committee of the New York State Legislature on March 7, 2006. My observation that people can feel vibration or pulsations from wind turbines, and find it disturbing, was quoted in the brief section "Impacts on Human Health and Well-Being" in the report *Environmental Impacts of Wind-Energy Projects* of the National Academy of Science, published in May 2007. No other medical information was cited in this report. The authors asked for more information to better understand these effects.⁷

Debates about wind turbine-associated health problems have been dominated to date by noise control engineers, or acousticians, which is problematic in part because the acoustics field at present is dominated by the wind turbine industry,⁸ and in part because acousticians are not trained in medicine. A typical approach to wind turbine disturbance complaints, world-wide, is *noise first, symptoms second*: if an acoustician can demonstrate with noise measurements that there is no noise considered significant in a setting, then the symptoms experienced by people in that setting can be, and frequently are, dismissed. This has been the experience of seven of the ten families in this study in the United States, Canada,

⁶ George Kamperman, personal communication, 2/21/2008. See <http://www.kamperman.com/index.htm>

⁷ National Research Council. 2007. *Environmental Impacts of Wind-Energy Projects*. The National Academies Press, Washington, DC. 185 pp, p. 109.

⁸ George Kamperman, personal communication, 2/23/2008.

Ireland, and Italy.⁹ At least one developer has put forward the hypothesis that a negative attitude or worry towards turbines is what leads people to be disturbed by turbine noise.¹⁰

A reorientation is in order. If people are so disturbed by their headaches, tinnitus, sleeplessness, panic episodes, disrupted children, or memory deficits that they must move or abandon their homes to get away from wind turbine noise and vibration, then that noise and vibration is by definition significant, because the symptoms it causes are significant. The role of an ethical acoustician is to figure out what type and intensity of noise or vibration creates particular symptoms, and to propose effective control measures.

My study subjects make it clear that their problems are caused by noise and vibration. Some symptoms in some subjects are also triggered by moving blade shadows. However, I do not present or analyze noise data in this study, because noise is not my training. (Conversely, symptoms and disease are not the training of acousticians.) I focus on detailed symptomatic descriptions and statistical evaluation of medical susceptibility factors within the study group. Correlating the noise and vibration characteristics of the turbine-exposed homes with the symptoms of the people in the homes is an area ripe for collaboration between medical researchers and independent noise control engineers.

Other than articles on the Internet, there is currently no published research on wind turbine-associated symptoms. A UK physician, Dr. Amanda Harry, whose practice includes patients living near wind turbines, has published online the results of a checklist survey, documenting specific symptoms among 42 adults who identified themselves to her as having problems while living 300 m to 1.6 km (984 ft to 1 mi) from turbines.¹¹ She found a high prevalence of sleep disturbance, fatigue, headache, migraine, anxiety,

⁹A notable exception to this pattern is the work of GP van den Berg, PhD, who, as a graduate student and a member of the Science Shop for Physics of the University of Groningen in the Netherlands, investigated noise complaints near a wind turbine park and devised new models of atmospheric noise propagation to fit the phenomena he observed. References: 1) van den Berg, GP. 2004. Effects of the wind profile at night on wind turbine sound. *Journal of Sound and Vibration* 277: 955-970; 2) van den Berg, GP. 2004. Do wind turbines produce significant low frequency sound levels? 11th International Meeting on Low Frequency Noise and Vibration and Its Control, Maastricht, The Netherlands, 30 August to 1 September 2004, 8 pp.; 3) van den Berg, GP. 2005. The beat is getting stronger: the effect of atmospheric stability on low frequency modulated sound of wind turbines. *Journal of Low Frequency Noise, Vibration, and Active Control*, 24(1): 1-24; 4) van den Berg, GP. 2006. The sound of high winds: the effect of atmospheric stability on wind turbine sound and microphone noise. PhD dissertation, University of Groningen, The Netherlands. 177 pp. <http://irs.ub.rug.nl/ppn/294294104>

¹⁰"We often use the word 'noise' to refer to 'any unwanted sound.' It's true that wind turbines make sounds... but whether or not those sounds are 'noisy' has a lot to do with who's listening. It's also worth noting that studies have shown [no references provided in source document] that a person's attitude toward a sound – meaning whether it's not 'wanted' or 'unwanted' sound – depends a great deal on what they think and how they feel about the source of the sound. In other words, if someone has a negative attitude to wind turbines, or is worried about them, this will affect how they feel about the sound. However, if someone has a positive attitude toward wind energy, it's very unlikely that the sounds will bother them at all." *Wind fact sheet #5: Are modern wind turbines noisy?* Noble Environmental Power, LLC, <http://www.noblepower.com/faqs/documents/06-08-23NEP-SoundFromWindTurbines-FSS-G.pdf>, p. 2.

¹¹Harry, Amanda. February 2007. Wind turbines, noise, and health. 32 pp. http://www.windturbineoisehealthhumanrights.com/wtnoise_health_2007_a_harry.pdf

depression, tinnitus, hearing loss, and palpitations. Respondents described a similar set of symptoms and many of the same experiences that I document in this report, including having to move out of their homes because of symptoms. Respondents were mostly older adults: 42% were age 60 or older, 40% age 45-60, 12% age 30-45, and 5% age 18-30. A biomedical librarian, Barbara Frey, working with this physician and others, has published online a compilation of other personal accounts of symptoms and sensations near wind turbines.¹² These also mirror what I document.

Robyn Phipps, PhD, a New Zealand scientist specializing in health in indoor environments, systematically surveyed residents up to 15 km (9.3 mi) from operating wind turbine installations, asking both positive and negative questions about visual, noise, and vibration experiences.¹³ All respondents (614 or 56% of the 1100 households to whom surveys were mailed) lived at least 2 km (1.24 mi) from turbines, with 85% of respondents living 2-3.5 km (1.24-2.2 mi) from turbines and 15% farther away. Among other questions, the survey asked about unpleasant physical sensations from turbine noise, which were experienced by 2.1% of respondents, even at these distances. Forty-one respondents (6.7%) spontaneously telephoned Dr. Phipps to tell her more than was asked on the survey about their distress due to turbine noise and vibration, nearly all (39) with disturbed sleep.¹⁴ Symptoms were not further differentiated in this study, but clearly may occur at distances even greater than 2 km (1.24 mi) from turbines.

Published survey studies have examined residents' reactions to wind turbines relative to modeled noise levels and visibility of turbines in Sweden^{15,16,17} and the Netherlands.^{18,19,20} The study in the Netherlands included questions on health and stress (see below, *Discussion*). Both sets of studies, the Swedish and

¹² Frey, Barbara J and Hadden, Peter J. February 2007. Noise radiation from wind turbines installed near homes: effects on health. 137 pp. http://www.windturbineoisehealthhumanrights.com/wtrnhhr_june2007.pdf

¹³ Phipps, Robyn. 2007. Evidence of Dr. Robyn Phipps, in the matter of Moturimu wind farm application, heard before the Joint Commissioners 8th-26th March 2007, Palmerston North [New Zealand]. 43 pp. <http://www.wind-watch.org/documents/wp-content/uploads/hipps-moturimutestimony.pdf>

¹⁴ Phipps 2007

¹⁵ Pedersen E, Persson Waye K. 2004. Perceptions and annoyance due to wind turbine noise – a dose-response relationship. *J Acoust Soc Am* 116(6): 3460-70.

¹⁶ Pedersen E. 2007. Human response to wind turbine noise: perception, annoyance and moderating factors. Dissertation, Occupational and Environmental Medicine, Department of Public Health and Community Medicine, Goteborg University, Goteborg, Sweden. 86 pp.

¹⁷ Pedersen E, Persson Waye K. 2007. Wind turbine noise, annoyance and self-reported health and wellbeing in different living environments. *Occup Environ Med* 64(7): 480-6.

¹⁸ Pedersen E, Bouma J, Bakker R, van den Berg GP. 2008. Response to wind turbine noise in the Netherlands. *J Acoust Soc Am* 123(5): 3536 (abstract).

¹⁹ van den Berg GP, Pedersen E, Bakker R, Bouma J. 2008. Wind farm aural and visual impact in the Netherlands. *J Acoust Soc Am* 123(5): 3682 (abstract).

²⁰ van den Berg GP, Pedersen E, Bouma J, Bakker R. 2008. Project WINDFARMperception: visual and acoustic impact of wind turbine farms on residents. Final report, June 3, 2008. 63 pp. Summary:

<http://umcg.wewi.eldoc.uu.nl/FILES/root/Rapporten/2008/WINDFARMperception/WFp-final-summary.pdf>
Entire report: <https://dSPACE.hh.se/dSPACE/bitstream/2082/2176/1/WFp-final.pdf>

Dutch, make important contributions to the rational setting of noise limits near wind turbines (see *Discussion*).

With regard to official opinion, the National Academy of Medicine in France recommended in 2005 that industrial wind turbines be sited at least 1.5 km (0.93 mi) from human habitation due to health effects of low frequency noise produced by the turbines.²¹

Current wind turbines have three airfoil-shaped rotor blades attached by a hub to gears and a generator, which are housed in a bus-sized box (nacelle) at the top of a nearly cylindrical, hollow steel tower. The nacelle is rotated mechanically to face the blades into the wind. The blades spin upwind of the tower. The tower is anchored in a steel-reinforced concrete foundation. Turbines heights in this study were 100 to 135 m (328 to 443 ft) with hub heights 59 to 90 m (194 to 295 ft) and blade lengths 33 to 45 m (108 to 148 ft). Individual turbine powers were 1.5 to 3 MW. Clusters contained from 8 to 45 individual turbines (see Table 1B).

In this study, participants from all families described good and bad symptomatic periods correlated with particular sounds from the turbine installations, rate of turbine spin, or whether the turbines were turned towards, away from, or sideways relative to their homes. All participants identified wind directions and intensities that exacerbated their problems and others that brought relief. Many subjects described a quality of invasiveness in wind turbine noise, more disturbing than other noises like trains. Some stated that the noise wouldn't sound loud to people who did not live with it, or that noises described with benign-sounding terms like "swish" or "hum" were in reality very disturbing. Several were disturbed specifically by shadow flicker, which is the flashing of light in a room as the slanting sun shines through moving turbine blades, or the repetitive movement of the shadows across yards and walls. (These observations are documented in the individual accounts in the *Family Tables*.)

Wind turbines generate sound across the spectrum from the infrasonic to the ultrasonic,²² and also produce ground-born or seismic vibration.²³ "In the broadest sense, a sound wave is any disturbance that is propagated in an elastic medium, which may be a gas, a liquid, or a solid. Ultrasonic, sonic, and infrasonic waves are included in this definition... Sonic waves [are] those waves that can be perceived by

²¹ Le retentissement du fonctionnement des éoliennes sur la santé de l'homme, le Rapport, ses Annexes et les Recommandations de l'Académie nationale de médecine, 3/14/2006. 17 pp. http://www.academie-medicine.fr/sites_thematiques/EOLIENNES/chouard_rapp_14mars_2006.htm

²² van den Berg 2004

²³ Style, P, Stimpson I, Toon S, England R, and Wright M. 2005. Microseismic and infrasound monitoring of low frequency noise and vibrations from wind farms. Recommendations on the siting of wind farms in the vicinity of Eskdalemuir, Scotland. 125 pp. http://www.esci.keele.ac.uk/geophysics/News/windfarm_monitoring.html

the hearing sense of the human being. Noise is defined as any perceived sound that is objectionable to a human being."²⁴

Following the usual usage in noise literature, I use the word *vibration* to refer to disturbances in solid media, such as the ground, house structures, or the human body. When air-borne sound waves of particular energy (power) and frequency meet a solid object, they may set the object vibrating. Conversely, a vibrating solid object, such as the strings on a violin, can create sound waves in air. There is energy transfer in both directions between air-borne or fluid-borne sound waves and the vibration of solids. When I talk about noise and vibration together, I am referring to this continuum of mechanical energy in the air and in solids.

Energy in either form (sound or vibration) can impinge on the human body, and there may be multiple exchanges between air and solids in the path between a source and a human. The tissues of humans and other animals are semi-liquid to varying degrees, and have fluid-filled and air-filled spaces within them, as well as solid structures like bones. As an example of such energy transfer, a sound wave in the air, encountering a house, may set up vibrations in the structure of the house. These vibrations, in walls or windows, may set up air pressure (sound) waves in rooms, which in turn can transmit mechanical energy to the tympanic membrane and middle ear, to the airways and lungs, and to body surfaces. Alternatively, vibrations in house structures or the ground may transmit energy directly to the body by solid-to-solid contact and be conducted through the body by bone conduction.

All parts of the body (and indeed all objects) have specific resonance frequencies, meaning *particular frequencies or wavelengths of sound will be amplified in that body part*.²⁵ If the wavelength of a sound or its harmonic matches the dimensions of a room, it may set up standing waves in the room with locations where the intersecting, reverberating sound waves reinforce each other. Resonance also occurs inside air-filled body cavities such as the lungs, trachea, pharynx, middle ear, mastoid, and gastrointestinal tract. The elasticity of the walls and density of the contents of these spaces affect the dynamics of sound waves inside them. The orbits (bones surrounding the eyes) and cranial vault (braincase) are also resonance chambers, because of the lower density of their contents compared to the bones that surround them. There are also vibratory resonance patterns along the spine (which is elastic), including a resonance

²⁴ Beranek, LL. 2006. Basic acoustical quantities: levels and decibels. Chapter 1 in Ver IL, Beranek LL, *Noise and Vibration Control and Engineering: Principles and Applications*. John Wiley and Sons, Hoboken, NJ. 976 pp., p. 1.

²⁵ Hedge, Alan, Professor, Cornell University, Department of Design and Environmental Analysis, syllabus/lecture notes for DEA 350: Whole-Body Vibration, January 2007, found at <http://ergo.human.cornell.edu/studentdownloads/DEA325pdfs/Human%20Vibration.pdf>

involving the movement of the head relative to the shoulders. Von Gierke^{26,27} and Rasmussen²⁸ have described the resonant frequencies of different parts of the human body.

Noise intensity is measured in decibels (dB), a logarithmic scale of sound pressure amplitude. Single noise measurements or integrated measurements over time combine the energies of a range of frequencies into a single number, as defined by the filter or weighting network used during the measurement. The A weighting network is the most common in studies of community noise. It is designed to duplicate the frequency response of human hearing. A-weighting augments the contributions of sounds in the 1000 to 6000 Hz range (from C two octaves above middle C, key 64 on the piano, to F# above the highest note on the piano), and progressively reduces the contributions of lower frequencies below about 800 Hz (G-G# 1½ octaves above middle C, keys 59-60). At 100 Hz, where the human inner ear vestibular organ has a peak response to vibration²⁹ (G-G# 1½ octaves below middle C, keys 23-24), A-weighting reduces measurement by a factor of 1000 (30 dB). At 31 Hz (B, the second-to-bottom white key, key 3), A-weighting reduces sound measurement by a factor of 10,000 (40 dB). Thus A-weighting preferentially captures the high sounds used in language recognition, to which the human cochlea is indeed very sensitive, but reduces the contribution of mid- and lower-range audible sounds, as well as infrasound (defined as 20 Hz and below).

Linear (lin) measurements use no weighting network, so the frequency responses are limited by other aspects of the system, such as microphone sensitivity. Linear measurements may capture low-frequency sounds but are not standardized – different sound level meters yield different results. As a result, the standardized and commonly available C weighting network is preferred for measuring environmental noise with low-frequency components, such as noise from wind turbines. The C weighting network has a flat response (meaning that it does not reduce or enhance the contributions of different frequencies) over the audible frequency range and a well-defined decreasing response below 31 Hz.

One third (1/3) octave band studies are used to describe sound pressure levels by frequency, and are presented as a graph rather than a single number. One third (1/3) octave bands can also be measured linearly or with weighting networks.

²⁶ von Gierke HE, Parker DE. 1994. Differences in otolith and abdominal viscera graviceptor dynamics: implications for motion sickness and perceived body position. *Aviat Space Environ Med* 65(8): 747-51.

²⁷ von Gierke HE. 1971. Biodynamic models and their applications. *J Acoust Soc Am* 50(6): 1397-413.

²⁸ Rasmussen G. 1982. Human body vibration exposure and its measurement. *Bruel and Kjaer Technical Paper No. 1*, Naerum, Denmark. Abstract: Rasmussen G. 1983. Human body vibration exposure and its measurement. *J Acoust Soc Am* 73(6): 2229.

²⁹ Todd NPMc, Rosengren SM, Colebatch JG. 2008. Tuning and sensitivity of the human vestibular system to low-frequency vibration. *Neuroscience Letters* 444: 36-41.

telephone about further developments. All ten families have reviewed the information presented about them and signed permission for anonymous publication.

I use simple statistical tests ($2 \times 2 \chi^2$) to examine associations among symptoms and between pre-existing conditions and symptoms during exposure.³¹ Degrees of freedom (df) is 2 for all the χ^2 results in this report. Children were excluded from the analysis of adult symptoms if no child younger than a certain age had the symptom in question. Study children were categorized into developmental-age blocks (see Table 1C). When I excluded children from an analysis, I excluded all the children in that age block and below. Excluding children from adult symptom analyses avoided inflating the no symptom/absent pre-existing condition box of the $2 \times 2 \chi^2$ contingency tables, which could artificially increase the χ^2 value.

Results

I interviewed 23 adult and teenage members of 10 families, collecting information on all 38 adult, teen, and child family members. One family member was a baby born a few days before the family (A) moved out, so there is no data for this child on sleep or behavior during exposure (which was in utero). Thus the sample size of subjects for whom we have information about experiences or behavior during exposure is 37.

Residence status and family composition are detailed in Table 1A; turbine, terrain, and house characteristics in Table 1B; and the age and sex distribution of subjects in Table 1C. Twenty subjects were male and 18 female, ranging in age from <1 to 75. Seventeen subjects were age 21 and below, and 21 subjects were age 32 and above. There is a gap in the 20's and a preponderance of subjects in their 50's. Wind turbine brands to which study subjects were exposed included Gamesa, General Electric, Repower, Bonus (Siemens), and Vestas.

Individual accounts of baseline health status and pre-exposure, during exposure, and post-exposure symptoms or absence of symptoms are presented in Family Tables A through J, with a separate sub-table for each individual. I encourage the reader to read these, because they highlight the before-during-after comparisons for each person, show how the symptoms fit together for individuals, reveal family patterns, and provide subjects' own words for what they feel and detect. When individuals are referred to in the

³¹ Sokal RR, Rohlf FJ. 1969. *Biometry*. WH Freeman and Co., San Francisco. 776 pp.

text, the letter and number in parentheses (e.g., A1, C2) refers to the family sub-table in which that subject's information is found.

Baseline conditions

Eight adult subjects had serious baseline medical conditions, including lupus (1), breast cancer (2), diabetes (1), coronary artery disease (2), hypertension (1), atrial fibrillation with anticoagulation (1), Parkinson's disease (1), ulcer (1), and fibromyalgia (2). Two were male (age 56-64) and six female (age 51-75). Other baseline medical conditions are listed in Table 2. Four subjects smoked at the beginning of exposure, and five others had smoked in the past (Table 2). There were no seriously ill children in the sample.

Seven subjects had histories of mental health disorders including depression, anxiety, post-traumatic stress disorder (PTSD), and bipolar disorder. Three were male (age 42-56) and four female (age 32-64). One of these men (age 56) also had Alzheimer's disease. There were no children with mental health disorders or developmental disabilities in this sample.

Eight subjects had pre-existing migraine disorder (including two with previous severe sporadic headaches that I interpreted as migraine). Four were male (age 19-42) and four female (age 12-42). An additional seven subjects, age <1 to 17, were children of migraineurs who had not experienced migraines themselves at baseline.

Eight subjects had permanent hearing impairments, defined subjectively or objectively, including mild losses, losses limited to one ear, or impairments of binaural processing. Six were male (age 32-64) and two female (age 51-57).

Six subjects had continuous tinnitus or a history of multiple, discrete episodes of tinnitus prior to exposure. Four were male (age 19-64) and two female (age 33-57).

Twelve subjects had significant previous noise exposure, defined as working in noisy industrial or construction settings; working on or in a diesel boat, truck, bus, farm equipment, or aircraft; a military tour of duty; or operating lawn mowers and chain saws for work. Not included were home or sporadic use of lawn mowers and chain saws, commuting by train or airplane, urban living in general, or playing or

listening to music. Nine of the noise-exposed subjects were male (age 19-64) and three female (age 33-53).

Eighteen subjects were known to be motion sensitive prior to exposure, as defined by carsickness as a child or adult, any episode of seasickness, or a history of two or more episodes of vertigo. Ten were male (age 6-64) and eight female (age 12-57).

Seven subjects had a remembered history of a single concussion, and none had a history of a more severe head injury. Six were male (age 19-59) and one female (age 12). I did not collect information on whiplash injury.

Core symptoms

Core symptoms are defined as 1) common and widely described by study participants, 2) closely linked in time and space to turbine exposure, and 3) amenable to diagnosis by medical history. Core symptoms include sleep disturbance, headache, tinnitus, other ear and hearing sensations, disturbances to balance and equilibrium, nausea, anxiety, irritability, energy loss, motivation loss, and disturbances to memory and concentration.

An additional core symptom is a new type of internal or visceral sensation which has no name in the medical lexicon. Subjects struggled to explain these sensations, often apologizing for how strange their words sounded. A physician subject called it "feeling jittery inside" or "internal quivering." Other subjects chose similar words, while others talked about feeling pulsation or beating inside. The physical sensations of quivering, jitteriness, or pulsation are accompanied by acute anxiety, fearfulness, or agitation, irritability, sleep disturbance (since the symptom arises during sleep or wakefulness), and episodes of tachycardia. I call this sensation and accompanying symptoms *visceral vibratory vestibular disturbance* (VVVD). It is described further below.

Core symptoms are closely correlated with exposure, including being at home, the direction and strength of the wind, whether turbines are facing the home, and the presence of moving blade shadows. Core symptoms all resolve immediately or within hours away from the turbines, with the exception of disturbances of concentration and memory, which resolved immediately in some cases or improved over weeks to months in others.

Sleep disturbance. Thirty-two subjects (17 males age 2-64 and 15 females age 2-75) had disturbed sleep. Types of sleep disturbance included: difficulty getting to sleep, frequent or prolonged awakening by turbine noise, frequent or prolonged awakening by awakened children, night terrors (both 2½-year-olds, B3 and G5), nocturnal enuresis (one 5-year-old girl, G4), nocturia (six women age 42-75 and one man age 64; B2, C2, E2, F2, F4, H2, D1), excessive movement during sleep (one 8-year-old boy, H3), excessive nighttime fears (two 5-year-olds, a girl and a boy, C8 and G4), and abrupt arousals from sleep in states of fear and alarm (four women age 42-57; C2, F2, H2, I2). Other adults, though not fearful when they woke up, awoke with physical symptoms similar to their daytime symptoms of anxiety/agitation/internal quivering (three men age 42-64 and two women age 32-53; D1, F1, J1, B2, G2). Four people slept well, including the one infant (G6), a 19-year-old woman (B3), a 47-year-old woman (I2) and her 8-year-old son (J4). It was unclear whether a 56 year-old man with dementia, bipolar disorder, Parkinson's disease, and disturbed sleep at baseline (E1) slept worse than usual or not.

With three exceptions, all types of sleep disturbance resolved immediately whenever subjects slept away from their turbine-exposed homes, including the adult nocturia and the 5-year-old's nocturnal enuresis. A 49-year-old man with a preexisting sleep disturbance (J1) took two nights to get back to his baseline, and a 45-year-old man (C1) and a 42-year-old man (F1) did not improve all the way to baseline, thought to be due to coexisting depression after abandoning their homes.

Headache. Nineteen subjects experienced headaches that were increased in frequency, intensity, and/or duration compared to baseline for that person. Eight were male (age 6-55) and eleven female (age 12-57). Eight had pre-existing migraine (C2, C3, C4, C5, C6, F1, G1, G2). Two women (one a migraineur, one not; C2, E2) had severe headaches provoked by shadow flicker. All other exposure-related headaches were triggered by noise alone. Recovery from headaches generally took several hours after the exposure ended.

Headache risk factors were examined in a subset of the study group that included all subjects age 5 and older (N=34), since the younger children in the study (age <1 to 2) were not reliable sources of information on headache. The occurrence of unusually severe or frequent headaches during exposure was significantly associated with pre-existing migraine disorder ($\chi^2 = 8.26, p = 0.004$). All 8 subjects with pre-existing migraine experienced headaches that were unusually intense, frequent, or prolonged compared to their baseline headaches. Of the 26 subjects without pre-existing migraine, 11 also experienced unusual or severe headaches during exposure. Two of these were children of migraineurs not

known to have migraine themselves (a girl age 17 and a boy age 6; F3, G3). All children or teens (through age 21) who had headaches during exposure were migraineurs or children of migraineurs.

Once migraine was factored out as a risk factor, 9 of 17 subjects over age 22 without a history of migraine still had headaches of increased intensity, duration, or frequency during exposure to turbines. I found no significant correlation within this group between headache and the presence of serious underlying medical illness ($\chi^2 = 0.486$, $p = 0.486$), present or past mental health disorder ($\chi^2 = 0.476$, $p = 0.490$), tinnitus or hearing loss at baseline, motion sensitivity at baseline, or tinnitus, disequilibrium, or VVVD during exposure.

In summary, a little more than half (19) of the 34 study participants age 5 and older experienced unusually severe headaches during exposure. Migraine was a statistically significant risk factor but was present in less than half (8) of the 19 subjects with worsened headache. Children and teens up to age 21 with headaches either had known migraine or were the children of migraineurs. Nine of the 19 headache subjects were adults without clear risk factors, showing that while people with migraine are more likely to have headaches of unusual intensity, duration, or frequency around turbines, so can other adults without identified risk factors.

Tinnitus and ear sensations. Fourteen subjects (nine males age 19-64 and five females age 33-57) experienced tinnitus that was new or worse in severity or duration than at baseline. For two men (age 55 and 64; B1, D1), the tinnitus at times interfered with their ability to understand conversation. Four of the 14 subjects experienced particularly disturbing kinds of tinnitus or noise which was perceived to be inside the head (two men age 42-55 and two women age 52-57; B1, F1, H2, I2). This sensation was painful for two subjects. Tinnitus tended to resolve over several hours after exposure ended.

Tinnitus risk factors were examined in subjects age 16 and older, since the youngest person with tinnitus was in this age group. The subject with dementia (E1) was excluded, since there was no information on his hearing status or tinnitus. Sample size was 24 subjects. The occurrence of new or worsened tinnitus in the presence of turbines was significantly correlated with previous noise exposure ($\chi^2 = 6.17$, $p = 0.013$), tinnitus prior to exposure ($\chi^2 = 5.71$, $p = 0.017$), and baseline hearing loss ($\chi^2 = 4.20$, $p = 0.040$). Tinnitus during exposure did not show a significant relationship with pre-existing migraine or motion sensitivity, or with headache or VVVD during exposure. Tinnitus during exposure showed a weak correlation with dizziness/disequilibrium during exposure ($\chi^2 = 3.60$, $p = 0.058$).

Eleven subjects during exposure experienced ear popping, ear or mastoid area pressure, ear pain without infection, or a sensation that the eardrum was moving but not producing a sensation of sound (six males age 2-55 and five females age 19-57). The 2½ year old (A3) pulled on his ears and got cranky repeatedly at the same time as his grandmother's (B2) exacerbations of headache, tinnitus, and ear pain. Five subjects experienced tickling, blowing, or undefined sensations in the external auditory canal, or increased wax production (two men age 42-55 and three women age 52-75).

Balance and equilibrium. Sixteen subjects (seven males age 19-64 and nine females age 12-64) experienced disturbance to their balance or sense of equilibrium during exposure, describing dizziness, light-headedness, unsteadiness, or spinning sensations. One of them, a 42-year-old woman (C2), described how a friend, sitting next to her in her turbine-exposed home, remarked how her eyes appeared to be bouncing back and forth (nystagmus). Ten of these 16 subjects also experienced nausea during exposure to turbines, during or separate from dizziness. No children under the age of 12 had symptoms of dizziness, disequilibrium, or nausea during exposure, except for the usual nausea of acute gastrointestinal and other infections.

Risk factors for dizziness/disequilibrium in the presence of turbines were analyzed using subjects age 12 and up, since this was the youngest age child with this type of symptom. The subject with Parkinson's disease and dementia (E1) was excluded because his baseline balance problems and inability to express himself made it hard for his wife (the informant) to tell if he had worsened symptoms during exposure or not. The remaining sample was 24 subjects. Disequilibrium during exposure is significantly correlated with headaches during exposure ($\chi^2 = 5.08$, $p = 0.024$) and baseline motion sensitivity ($\chi^2 = 4.20$, $p = 0.040$). Disequilibrium during exposure is weakly correlated with tinnitus during exposure ($\chi^2 = 3.60$, $p = 0.054$); inspection of the data shows that these are primarily ataxic (unsteady) subjects. Dizziness/disequilibrium during exposure is not correlated with VVVD during exposure, pre-existing migraine disorder, previous noise exposure, or prior tinnitus or hearing loss.

Internal quivering, vibration, or pulsation. Eleven adult subjects described these uncomfortable, unfamiliar, and hard-to-explain sensations:

- Dr. J (J1, age 49) described "internal quivering" as part of the "jittery feeling" he has when the turbines are turning fast.

- Mrs. I (I2, age 52) said the noise inside her house is "low, pulsating, almost a vibration," not shut out by earplugs. She gets a sensation inside her chest like "pins and needles" and chest tightness on awakening at night to noise. "It affects my body – this is the feeling I get when I say I'm agitated or jittery. It's this that gives me pressure or ringing in my ears." "A feeling someone has invaded not only my health and my territory, but my body."
- Mrs. H (H2, age 57) described a pulsation that prevented sleep from the "unnatural" noise from the turbines.
- Mr. G (G1, age 35) described feeling disoriented and "very strange" in certain parts of the house where he could "feel rumbling." If he did not move quickly away from these locations, the feeling would progress to nausea. He described the noise as "at times very invasive. Train noise has a different quality, and is not invasive."
- Mrs. G (G2, age 32) felt disoriented, "light-headed," dizzy, and nauseated in her garden and in specific parts of the house where she detected vibration. She felt her body vibrating "inside," but when she put her hand on walls, windows, or objects, they did not seem to be vibrating.
- Mrs. F (F2, age 51) described a physical sensation of noise "like a heavy rock concert," saying the "hum makes you feel sick."
- Mrs. E (E2, age 56), when supine, felt a "ticking" or "pulsing" in her chest in rhythm with the audible swish of the turbine blades. She interpreted this as her "heart synchronized to the rhythm of the blades," but there is no information (such as a pulse rate from the wrist at the same time) to determine whether this was true or not, or whether she detected a separate type of pulsation. Mrs. E could make these sensations go away by getting up and moving around, but they started again when she lay back down.
- Mr. D (D1, age 64) felt pulsations when he lay down in bed. In addition, "When the turbines get into a particular position (facing me), I get real nervous, almost like tremors going through your body...it's more like a vibration from outside...your whole body feels it, as if something was vibrating me, like sitting in a vibrating chair but my body's not moving." This occurs day or night, but not if the turbines are facing "off to the side."

- Mr. C (C1, age 45) felt pulsations in his chest that would induce him to hold his breath, fight the sensation in his chest, and not breathe "naturally." Chest pulsations interrupted his sleep and ability to read. He also described a sensation of "energy coming within me...like being cooked alive in a microwave."
- Mrs. B (B2, age 53) described her breath being "short every once in a while, like [while] falling asleep, my breathing wanted to catch up with something."
- Mr. B (B1, age 55) had two episodes of feeling weight on his chest while lying down, which resolved when he stood up. Other than this, he experienced the invasive quality of the noise in his head and ears: "That stuff [turbine noise] doesn't get out of your head, it gets in there and just sits there – it's horrible."

Agitation, anxiety, alarm, irritability, nausea, tachycardia, and sleep disturbance are associated with internal vibration or pulsation:

- Dr. J's (J1, age 49) "jittery" feeling includes being "real anxious," irritable, and "no fun to be around." He interrupts outdoor and family activities to sequester himself in his well-insulated house. When the turbine blades are spinning fast and he detects certain types of noise and vibration as he arrives home from work, he gets queasy and loses his appetite. He awakens from sleep with the "jittery" feeling and tachycardia, and may need to go downstairs to a cot in the 55 degree root cellar (the only place on his property where he cannot hear or feel the turbines) to be able to fall back to sleep. He often takes deep breaths or sighs when in the "jittery" state.
- Mrs. I (I2, age 52) describes episodic "queasiness and nausea" with loss of appetite, "trembling in arms, legs, fingers," "strong mental and physical agitation," and frequent unexpected crying. On noisy nights she awakens after four hours of sleep, weeping in the night. "When I wake up, [there is] more a feeling of pressure and tightness in my chest; it makes me panic and feel afraid." It is "a startling sort of waking up, a feeling there was something and I don't know what it was." Once she awoke thinking there had been an earth tremor (there had not), and twice she has awakened with tachycardia, the "feeling your heart is beating very fast and very loud, so I can feel the blood pumping." Feelings of panic keep her from going back to sleep.

- Mrs. H (H2, age 57) awakens 5-6 times per night with a feeling of fear and a compulsion to check the house. She describes it as a "very disturbed sort of waking up, you jolt awake, like someone has broken a pane of glass to get into the house. You know what it is but you've got to check it – go open the front door – it's horrific." She finds it hard to fall back to sleep and describes herself as irritable and angry, shouting more at her family members.
- Mr. G (G1, age 35) described the noise outside his home and the noise that awakened him at night "stressful."
- Mrs. G (G2, age 32) was, during exposure, irritable, angry, and worried about the future and her children. She awoke often at night because her children woke up, when she cared for their fears, mentioning none of her own.
- Mrs. F (F2, age 51) described a "feeling of unease all the time." At night she startles awake with heart pounding, a feeling of fear, and a compulsion to check the house. The feeling of alarm keeps her from being able to go back to sleep.
- Mrs. E (E2, age 56) did not express anxiety or fear, but she awakened repeatedly at night and was unable to get back to sleep on nights when the turbines were facing the house.
- Mr. D (D1, age 64) described how he has to "calm down" from the "tremor." If outside, "I come in, sit down in my chair and try to calm myself down. After an episode like that, I'm real tired." Mood has worsened with increased anger, frustration, and aggression. Tachycardia accompanies the "tremor" at times: "My heart feels like it's starting to race like crazy and I have these tremors going through my body." Mr. D pants or hyperventilates when the tremor and tachycardia occur, and consciously slows his breathing when calming down.
- Mr. C (C1, age 45) was unable to rest, relax, or recuperate in his home, where his body was "always in a state of defense." He had to drive away in his car to rest.
- Mrs. B (B2, age 53) became "upset and in a turmoil" when her symptoms were worse, leaving her house and tasks repeatedly to get relief.

- Mr. B (B1, age 55) described stress, "lots, pretty near more'n I could take, it just burnt me, the noise and run-around." He was prescribed an anxiolytic, and spent more time at the shore and his boat for symptom relief.

The internal quivering, vibration, or pulsation and the associated complex of agitation, anxiety, alarm, irritability, tachycardia, nausea, and sleep disturbance together make up what I refer to as *visceral vibratory vestibular disturbance* (VVVD). Fourteen adult subjects (six men age 35-64 and eight women age 32-75) had VVVD during exposure, including the eleven quoted above and Mr. F (F1, age 42), Mrs. F Senior (F4, age 75), and Mrs. C (C2, age 42). Mr. I (I1, age 59) had partial symptoms, with urge to escape, noise-induced nausea, and sleep disturbance, but no feeling of internal movement. VVVD resolves immediately upon leaving the vicinity of the turbines, when the turbines are still and silent, and under favorable weather conditions at each locality.

Because VVVD is in part a panic attack, accompanied by other physical and mental symptoms, I examined the relationships among VVVD and panic disorder, other mental health diagnoses, and other risk factors. The sample for this analysis was 21 adults ages 22 and above (since the study had no participants age 22-29, this is the same for this study as starting with the age group of the youngest symptomatic subjects, who were 32).

No study subjects had pre-existing panic disorder or previous isolated episodes of panic, so there was no correlation between pre-existing panic and VVVD. Seven subjects had immediate pre-exposure (2 subjects) or past histories (5 subjects) of mental health disorders including depression, anxiety, post-traumatic stress disorder (PTSD), and bipolar disorder. There was no correlation between immediate pre-exposure or past mental health disorder and VVVD ($\chi^2 = 0.429$, $p = 0.513$). There was, however, a highly significant correlation between VVVD and motion sensitivity ($\chi^2 = 7.88$, $p = 0.005$).

There was also a moderately significant correlation between VVVD and headaches during exposure ($\chi^2 = 4.95$, $p = 0.026$). There was no correlation between VVVD and dizziness or tinnitus during exposure, or between VVVD and pre-existing migraine, tinnitus, or hearing loss.

Concentration and memory. Twenty of the 34 study subjects age 4 and up (eleven males age 6-64 and nine females aged 5-56) had salient problems with concentration or memory during exposure to wind turbines compared to pre- and/or post-exposure. This is a conservative count, including only subjects whose accounts included specific information on decline in school and homework performance (for

children and teens) or details on loss of function for adults. Eight other subjects had some disturbance to concentration and memory, but symptoms were milder or the descriptions more vague (in their own or parents' accounts). Five others subjects, all older adults, noted no change compared to pre-existing memory problems. This leaves only one subject, a 19-year-old woman home from college and minimally exposed (B3), who did not have baseline deficits and was unaffected.

Pre-exposure cognitive, educational, and work accomplishments, specific difficulties related to concentration and memory during exposure, and degree and timing of post-exposure recovery are documented in the Family Tables for each individual, under "Cognition." Difficulties are often striking compared to the subject's usual state of functioning:

- Mr. A (A1, age 32), a professional fisherman with his own boat, who had an isolated difficulty with memory for names and faces prior to exposure, became routinely unable to remember what he meant to get when he arrived at a store, unless he had written it down.
- Mrs. B (B2, age 53), a homemaker, got confused when she went to town for errands unless she had written down what she was going to do, and had to return home to get her list. When interviewed six weeks after moving, she reported that she had improved to being able to manage three things to do without a list.
- Mr. C (C1, age 45) had to put reading aside because he could not concentrate whenever he felt pulsations.
- Mrs. C (C2, age 42), a very organized mother of six who was "ready a month in advance for birthday parties" prior to exposure, became disorganized and had difficulty tracking multiple tasks at once, including while cooking, repeatedly boiling the water away from pots on the stove. She remarked, "I thought I was half losing my mind."
- Mr. D (D1, age 64), a disabled, retired industrial engineer, noticed progressive slowing of memory recall speed and more difficulty remembering what he had read.
- Mrs. E (E2, age 56), a retired teacher active in community affairs, could not spell, write e-mails, or keep her train of thought on the telephone when the turbine blades were turned towards the house, but was able to do these things when the blades were not facing the house.

- Mrs. F (F2, age 51), a nurse, child development specialist, midwife, and Masters level health administrator, could not follow recipes, the plots of TV shows, or furniture assembly instructions during exposure.
- Mrs. G (G2, age 32), a well-organized mother of four, was forgetful, had to write everything down, could not concentrate, and could not get organized. She forgot a child's hearing test appointment. She did not have memory or concentration problems during a previous depression at age 18, and described her experience as "different this time."
- Mr. I (I1, age 59), a professional gardener, could not concentrate on his outdoor gardening and building tasks if the turbines were noisy, saying "after half an hour you have to leave, escape, close the door."
- Dr. J. (J1, page 49), a physician, noticed marked concentration problems when he sat down to pay bills in a small home office with a window towards the turbines.

Decline in school performance compared to pre-exposure, or marked improvement in school performance after moving away from turbines, was noted for 7 of the 10 study children and teens attending school (age 5-17; C7, F3, G3, G4, H3, J3, J4). For example:

- A 17-year-old girl (F3), a diligent student, was not concerned about the turbines and thought her parents were overdoing their concern until she unexpectedly did worse on national exams than the previous year, surprising her school, family, and self. At this point she began accompanying her parents to their sleeping house.
- A 9-year-old boy (C7), whose school work was satisfactory without need for extra help prior to exposure, failed tests, lost his math skills, and forgot his math facts. He could not maintain his train of thought during homework, losing track of where he was if he looked up from a problem.
- A 6-year-old boy (G3), described as an extremely focused child and advanced in reading prior to exposure, did not like to read during exposure. Two months post-exposure, now age 7, he would sit down to read on his own for an hour at a time, reading "quite a thick book" for his age.

- His 5-year-old sister (G4) had a short attention span prior to exposure. Her hearing loss due to bilateral chronic serous otitis media was thought to be interfering with school work during exposure, and she repeatedly had tantrums over schoolwork at home during the exposure period. Two months after moving, despite no change in her ears (on a waiting list for pressure equalization tubes), she was more patient and could work longer on homework. Her mother noted that her "schoolwork has improved massively."
- An 8-year old boy (H3) had an excellent memory and did well in reading, spelling, and math prior to exposure. During exposure he became resistant to doing homework, with tantrums, and his teacher told him he was not concentrating and needed to go to bed earlier.

In comparing the 20 subjects with salient concentration or memory changes to the 14 who had no change from baseline or vague/minimal difficulties, there are significant relationships with 1) baseline cognition, in that those without memory or concentration deficits at baseline are more likely to notice such deficits during exposure ($\chi^2 = 4.86, p = 0.027$); and 2) fatigue or loss of energy or enjoyment for usual activities during exposure ($\chi^2 = 5.61, p = 0.018$). There is no significant relationship between salient concentration or memory changes and pre-existing psychiatric diagnoses, migraine, motion sensitivity, or noise exposure, or between salient concentration or memory changes and headache, tinnitus, VVVD, or irritability during exposure.

In addition to the statistical association between fatigue and concentration disturbance, a number of subjects directly attributed their concentration problems to their sleep deprivation or disturbance. Several aspects of the data, however, suggest that other factors may also be involved.

First, one subject, Mrs. E (E2, age 56) could not do certain mental tasks requiring concentration when the turbines were turned towards her house, but could do them when the turbines were not turned towards the house. Mr. C (C1, age 45), Mr. I (I1, age 59), and Dr. J (J1, age 49) also had concentration problems closely linked in time and space to direct exposure to turbine noise.

Second, some of the problems described by subjects, such as Mrs. F (F2, age 51) and the members of families A and B, are more extreme than I expect from sleep deprivation. The degree of thinking dysfunction involved in not being able to follow a recipe or assemble a piece of furniture, in a woman both highly educated and involved in several practical professions (nursing and farming), does not match

my expectation of sleep deprivation from the experience, for example, of both younger and older physicians, who often function under sleep deprivation.

Third, some subjects had concentration problems without obvious sleep problems. All four members of family J had concentration problems, but only Dr. J (J1, age 49) was sleep deprived. Mrs. J (J2, age 47) fell asleep easily and usually went back to sleep if awakened, but still had problems with memory and focus in her home activities that she had noticed and attempted to treat. Their 13-year-old son (J3) needed white noise or music to drown out turbine noise to fall asleep, but went to sleep promptly, slept through the night, and did not complain in the morning of being tired or having slept poorly. His school performance and his level of distractibility at home, however, were both markedly different than at baseline. The younger son, age 8 (J4), continued to sleep well, but still had a surprising decline in school performance, though milder and of shorter duration than his brother's.

Fourth, the problems with concentration and memory resolve on a different schedule from the turbine-related sleep problems. Sleep problems resolve immediately except when accompanied by persistent depression (C1, F1). Problems with concentration and memory frequently took longer to improve, even in the absence of depression. To study resolution, we need to look at subjects who have moved away from their exposed homes or spent a prolonged period away that included work (families A, B, C, E, F, and G, and Mrs. I), since vacations do not provide the same challenges to concentration and memory. Of these 23 subjects over age 4, 13 had salient difficulties with concentration or memory:

- Mr. A (A1, age 32) rated his memory as 85% at baseline, 2% during exposure, and 10% six weeks after moving away.
- Mr. and Mrs. B (B1, B2, age 55 and 53) said their memories had partially recovered six weeks after moving.
- Mr. C (C1, now age 47), with continuing depression and ongoing exposure for house maintenance, noted 25 months after moving how bad his memory seemed.
- Mrs. C (C2, now age 44) felt she had recovered her memory and concentration 18 months after moving, despite ongoing stress from crowded living arrangements. Her affected son (now age 11, C7) had not completely recovered his school performance.

- Mrs. E (age 52) recovered immediately. She only experienced problems during exposure when the turbines were turned in a particular direction.
- Mr. and Mrs. F (F1, F2, ages 42 and 51) had moved away but still worked at their turbine-exposed home and farm during the day. Three months after they moved, both thought their concentration had improved, but not to baseline. Mr. F, with ongoing depression, did not perceive any memory recovery. I do not have information about their daughter's (F3, age 17) exam performance after moving.
- Mrs. G (G2, age 32) rated her memory as 10/10 at baseline, 2/10 during exposure, and 5/10 two months after moving away, at which point her depression was mostly resolved. Mrs. G's 5-year-old and 6-year-old children (G3, G4) showed marked improvements in concentration by two months after moving.

Only three subjects were clearly depressed during or after exposure. Mrs. G (G2, age 32) was becoming depressed at the time of the first (during exposure) interview. She remarked on the difference in her cognitive functioning between her current experience and a previous episode of depression at age 18, when she had no problem with her memory or concentration. Two other subjects, Mr. C (C1, age 45) and Mr. F (F1, age 42) developed depression after they had to abandon their homes, which was associated with prolonged memory difficulties. Both also had ongoing exposure.

Irritability and anger. Twenty-eight subjects (fifteen male age 2-64 and thirteen female age 2-64) perceived themselves or were noted by parents to be more angry, irritable, easily frustrated, impatient, rude, defiant, or prone to outbursts or tantrums than at baseline. The adults were uniformly apologetic about their own irritability, and several described how careful they were to avoid acting irritable in their households. Four children (three boys age 8-9 and a girl age 5; C7, G3, H3, G4) were markedly frustrated over homework. The young children of family G quarreled and had tantrums incessantly, and the six children/young adults in family C became angry, prickly, moody, defiant, or prone to fights at school. In families with children, the breakdown in children's behavior, social coping skills, and school performance was one of the strongest elements propelling them to move.

Fatigue and motivation. Twenty-one subjects felt or acted tired, and 24 had problems with motivation for usual, necessary, or formerly enjoyable activities (27 combined, fourteen male age 2-64 and thirteen female age 2-75). Like concentration and memory, these symptoms undoubtedly have a relationship with

sleep deprivation, but certain subjects described leaden feelings around turbines that resolved as soon as they left the vicinity, such as Mr. A (A1, age 32), who said, "You feel different up there: draggy, worn out before you even start anything.... It was a chore to walk across the yard." After driving an hour away to visit a family member, "I felt better all over, like you could do a cart wheel," and he felt well after moving.

When away from their turbine-exposed homes, most subjects recovered their baseline positive mood states, energy, and motivation immediately. Six adult subjects did not. These were Mr. B (B1, age 55), Mr. and Mrs. C (C1, C2, age 45 and 42), Mr. and Mrs. F (F1, F2, age 42 and 51), and Mrs. G (G2, age 32). By their own accounts, three (Mr. C, Mr. F, and Mrs. G) had unresolved or resolving depression. All but Mrs. G had ongoing anxiety and anger over abandoning their homes and their unresolved life situations.

Other symptom clusters and isolated problems

These symptoms and problems occurred in fewer subjects and typically require more than a medical history to diagnose. Several are exacerbations of pre-existing conditions with obvious connections to situations of high stress (cardiac arrhythmias, hypertension, irritable bowel, gastroesophageal reflux, glucose instability). Others are sequelae of core symptoms (auditory processing problems, unusual migraine aura). Others may indicate different kinds of direct effects of noise on body tissues, as in the vibroacoustic disease model of noise effects (respiratory infections, asthma, clotting abnormalities),³² or other types of secondary effects (asthma).³³

Respiratory infection/inflammation cluster: Seven subjects had unusual or prolonged lower respiratory infections during exposure (A2, B1, C2, E2, F1, F3, F4), and two of these also had prolonged asthma exacerbations (F1, F3). Four subjects had unusually severe or prolonged middle ear problems (C7, F2, G3, G4).

Cardiovascular cluster: Two subjects had exacerbations of preexisting dysrhythmias (F1, J2). Two women had hypertension that increased during and after the exposure period, requiring medication after

³² Castelo Branco NAA, Alves-Pereira M. 2004. Vibroacoustic disease. *Noise Health* 6(23): 3-20.

³³ Beasley R, Clayton T, Crane J, von Mutius E, Lai CK, Montefort S, Stewart A; ISAAC Phase Three Study Group. 2008. Association between paracetamol use in infancy and childhood, and the risk of asthma, rhinoconjunctivitis, and eczema in children aged 6-7 years: analysis from Phase Three of the ISAAC programme. *Lancet* 372(9643): 1039-48.

the end of the exposure period. Both still had considerable stress related to moving out and not being able to establish another regular home, and depressed husbands (C2, F2).

Gastrointestinal cluster. Four subjects had exacerbations of pre-existing gastroesophageal reflux (GER), ulcer, or irritable bowel, two with irritable bowel and upper gastrointestinal symptoms at the same time (D1, F1, F2, J2).

Arthralgia/ myalgia cluster. One healthy 32-year-old woman (G2) noted pain in one elbow while in her exposed house. It resolved when she went away for vacations with her family, and recurred when she returned. It resolved quickly when the family moved away, even though she did lots of lifting during the move. Two women (age 56-57; E2, H2) had exacerbations of fibromyalgia, both of which resolved after moving or during times away from their exposed home.

Diabetes control. A 56-year-old man with Type II diabetes (E1), stable on oral medications and insulin before exposure, had marked glucose instability accompanied by visual blurring, retinal changes, and polyuria during exposure.

Anticoagulation: A 75-year-old woman with atrial fibrillation (F4) had stable INR values on 2-4 mcg warfarin daily for 10 years. By 16 months of exposure, her warfarin dose had been increased to 8-9 mcg daily in response to decreasing INR values.

Auditory processing cluster. A woman (age 33, A2) had progressively worsening tinnitus during her five months of exposure. After she moved away, the tinnitus resolved and she noticed she had a new difficulty understanding conversation in a noisy room, now needing to watch the speaker's face carefully. Her son, age 27-32 months during exposure, did not confuse sounds before exposure but began to do so during exposure, and continued to do so when I interviewed mother six weeks after the exposure ended (A3). The child's language development was otherwise good. One woman (age 42, C2) had tinnitus throughout her 21 month exposure period without hearing changes. After she moved and the tinnitus resolved, she noted hyperacusis. Another woman (age 32, G2) experienced hyperacusis during exposure, but no tinnitus. The hyperacusis resolved after the family moved.

Ocular cluster: Three subjects exposed to the same turbines (two men age 32-55 and one woman age 53; A1, B1, B2) had ocular pain, pressure, and/or burning synchronously with headache and tinnitus. Mr. D

(D1, age 64) had a painless retinal stroke, losing half the vision in his left eye. Mr. D had a normal CT scan of the brain and was examined by an ophthalmologist.

Complex migraine phenomena. A 19-year-old fisherman (C4) with migraine at baseline had complex visual symptoms with flashes in square patterns in one eye at a time (scintillating scotoma), evolving to blurring and visual loss for 30 seconds to 2 minutes, also in one eye at a time (amaurosis fugax), right more than left, repetitively during the last month of his 15-21 month exposure until 8-12 months after exposure ended, with a decrease in frequency by 7 months after moving out. These events happened at any time of day and rarely overlapped with headaches or tinnitus. He had normal ophthalmologic exams, normal MRI and MRA scans of the brain and associated arteries, and a normal evaluation for clotting abnormalities and vasculitis. The events resolved completely with normal vision. The same man experienced repetitive complex basilar migraines with aura after the first few months of his 15-21 month turbine exposure, involving daily bilateral paresis and paresthesias of his legs and occasional headache, tinnitus, and light-headedness. The leg symptoms resolved on the same schedule as the eye symptoms, though headaches and nausea continue to be triggered regularly by seasickness.

Discussion

The core symptoms of Wind Turbine Syndrome are sleep disturbance, headache, tinnitus, other ear and hearing sensations, disturbances to balance and equilibrium, nausea, anxiety, irritability, energy loss, motivation loss, disturbances to memory and concentration, and *visceral vibratory vestibular disturbance* (VVVD). Core symptoms are defined as common and widely described by study participants, closely linked in time and space to turbine exposure, and amenable to diagnosis by medical history. The latter was a particular requirement of this study. The subjects of this study had other types of health problems during exposure, discussed in "Other symptom clusters and isolated problems," but different types of study will be needed to find out if there is a link between these problems and wind turbine exposure.

The most distinctive feature of Wind Turbine Syndrome is the group of symptoms I call *visceral vibratory vestibular disturbance*, or VVVD. The adults who experience this describe a feeling of internal pulsation, quivering, or jitteriness, accompanied by nervousness, anxiety, fear, a compulsion to flee or check the environment for safety, nausea, chest tightness, and tachycardia. The symptoms arise day or night, interrupting daytime activities and concentration, and interrupting sleep. Wakefulness is prolonged after this type of awakening. Subjects observe that their symptoms occur in association with specific

types of turbine function: the turbines turned directly towards or away from them, running particularly fast, or making certain types of noise. The symptoms create aversive reactions to bedroom and house. Subjects tend to be irritable and frustrated, especially over the loss of their ability to rest and be revitalized at home. Subjects with VVVD are also prone to queasiness and loss of appetite even when the full set of symptoms is not present.

There is no statistical association in this study between VVVD and pre-existing panic episodes (which occurred in none of the subjects) or other mental health disorders, such as depression, anxiety, bipolar disorder, or posttraumatic stress disorder. There is a highly significant association between VVVD and pre-existing motion sensitivity ($p = 0.005$).

Headaches more frequent or severe than at baseline occurred in all migraineurs in the study, and all children with headaches in the study were migraineurs or the children of migraineurs. Non-migrainous adults also got severe headaches around turbines, and indeed about half the people with headache worse than baseline (9 out of 19) were adults without history of migraine. Pre-exposure migraine is a significant risk factor for more severe or frequent headaches during turbine exposure ($p = 0.004$), but does not account for all the cases of headache.

Tinnitus occurred as a migraine aura in three subjects, but statistically in the study group tinnitus was not significantly associated with migraine, but rather with previous industrial noise exposure ($p = 0.013$), past history of tinnitus ($p = 0.017$), and baseline permanent hearing impairment ($p = 0.040$). I interpret tinnitus in these non-migrainous subjects as the direct impact of turbine noise on the cochlea, sensitized by previous inner ear damage from earlier noise exposure or chemotherapy.

Visceral vibratory vestibular disturbance (VVVD)

The work of Mittelstaedt on visceral detectors of gravity,³⁴ and Balaban and others on balance-anxiety linkages,^{35,36,37,38,39} opens a window on the VVVD symptom set. Balaban, a neuroscientist, has localized

³⁴ Mittelstaedt H. 1996. Somatic graviception. *Biol Psychol* 42(1-2): 53-74.

³⁵ Balaban CD, Yates BJ. 2004. The vestibuloautonomic interactions: a teleologic perspective. Chapter 7 in *The Vestibular System*, ed. SM Highstein, Fay RR, Popper AN, pp. 286-342. Springer-Verlag, New York.

³⁶ Balaban CD. 2002. Neural substrates linking balance control and anxiety. *Physiology and Behavior* 77: 469-75.

³⁷ Furman JM, Balaban CD, Jacob RG. 2001. Interface between vestibular dysfunction and anxiety: more than just psychogenicity. *Otol Neurotol* 22(3): 426-7.

³⁸ Balaban CD. 2004. Projections from the parabrachial nucleus to the vestibular nuclei: potential substrates for autonomic and limbic influences on vestibular responses. *Brain Res* 996: 126-37.

³⁹ Halberstadt A, Balaban CD. 2003. Organization of projections from the raphe nuclei to the vestibular nuclei in rats. *Neuroscience* 120(2): 573-94.

and described the neural connections among the vestibular organs of the middle ear, brain nuclei involved with balance processing, autonomic and somatic sensory inflow and outflow, the fear and anxiety associated with vertigo or a sudden feeling of postural instability, and aversive learning.⁴⁰ These form a coordinated, neurologically integrated system based in the parabrachial nucleus of the brainstem and an associated neural network.^{41,42} Several aspects of this system need to be considered here.

First, there appear to be not three but four body systems for regulating balance, upright posture, and the sense of position and motion in space. The first three systems are the eyes, the semicircular canals and otolith organs of the inner ear, and somatic input from skin, skeletal muscles, tendons, and joints. The fourth system is visceral detection of gravity and acceleration (meaning change in speed or direction of movement) by visceral graviceptors. These include stretch receptors in mesenteries or other connective tissue supporting organs or great vessels, and integrated systems of pressure detection in vessels and organs.⁴³ Such receptors have been found in the kidneys and in structures supporting the great vessels in the mediastinum, among other locations.⁴⁴ Von Gierke (an older dean of vibration studies for the US space program) considers the inter-modality sensory conflict between the abdominal visceral graviceptors and the otolith organs to be a possible cause of motion sickness.⁴⁵

The second critical element is central processing: how sensory information about motion and position is integrated by the brain, what other brain centers are activated, and what kinds of signals the brain then sends back out to the body. Balaban and colleagues describe how the parabrachial nucleus network receives motion and position information from visual, vestibular (inner ear), somatosensory, and visceral sensory input, and is linked to brain centers and circuits that mediate anxiety and fear, including the amygdala, a key mediator of fear reactions, and serotonin and norepinephrine-bearing neurons radiating from the midbrain.^{46,47,48} Our sense of balance and stability in space is closely connected – neurologically – to fear and anxiety.

⁴⁰ Balaban and Yates 2004

⁴¹ Balaban CD, Thayer JF. 2001. Neurological bases for balance-anxiety links. *J Anx Disord* 15: 53-79.

⁴² Balaban 2002

⁴³ Balaban and Yates 2004

⁴⁴ Vaitl D, Mittelstaedt H, Baisch F. 2002. Shifts in blood volume alter the perception of posture: further evidence for somatic graviception. *Int J Psychophysiol* 44(1): 1-11.

⁴⁵ von Gierke HE, Parker DE. 1994. Differences in otolith and abdominal viscera graviceptor dynamics: implications for motion sickness and perceived body position. *Aviat Space Environ Med* 65(8): 747-51.

⁴⁶ Balaban and Thayer 2001

⁴⁷ Balaban 2002

⁴⁸ Halberstadt and Balaban 2003.

Balaban illustrates with a story. He asks the reader to visualize waiting in traffic on a hill for a light to turn. Out of the corner of your eye you see the truck next to you starting to inch forward, and you jam your foot on the brake, since your sensory system has told you that you are starting to slip backwards. There's a bit of panic in that moment, quickly settled as you realize you are indeed stable in space and not moving. The story illustrates how a sensation of unexpected movement elicits alerting and fear. When the sense of movement is ongoing and cannot be integrated with the evidence of the other senses, as happens in vertigo, there is a more prolonged fear reaction. The association of fear with vertigo has been known since ancient times.⁴⁹

The third critical element is integrated neurologic outflow to the body from the parabrachial nucleus network to both the somatic (conscious, voluntary) and visceral (autonomic) effector systems. The somatic musculature is responsible for that fast foot on the brake, for righting movements of limbs, torso, and neck, and for breathing motions of the diaphragm and chest wall. The autonomic system is responsible for blood flow, heart rate, blood pressure, sweating, nausea, and other automatic, non-conscious modifications to visceral functioning. In a fear response, there is integrated outflow to these two systems. The parabrachial nucleus network is also involved in aversive learning,⁵⁰ an experience in which nausea, if present, plays a large role.

In VVVD, subjects detect unusual types of movement (pulsation, internal vibration, internal quivering) or other sensations (pressure, a sense of fighting something to breathe, pins and needles) in the chest or in the coordinated chest-abdominal internal space. The chest and abdomen are separated and unified by the diaphragm, which, as a striated somatic muscle, has fine-grained sensitivity to motion and stretch. The diaphragm sends signals to the brain which are specific and localizable in time and space, as opposed to visceral receptors, which send signals that are vague, like discomfort, malaise, fullness, or nausea. The diaphragm is tightly bound to one of the largest abdominal organs, the liver, and they move as a unit during breathing.

The chest, via the mouth, nose, trachea, smaller airways, and air sacs of the lungs, is open to the air. Pressure fluctuations in the air (sound waves) have free access to this airspace within the body when we breathe. Pressure fluctuations in the air also have access to the ear, which is designed to funnel them to the tympanic membrane, which concentrates their energy and transmits it to the inner ear. The ear and the

⁴⁹ Balaban and Thayer 2001

⁵⁰ Balaban and Thayer 2001

chest are different size spaces with walls of different mobility and elasticity. Hence they respond differently to air pressure fluctuations (sound waves) of different sizes.

Studies of whole body vibration focus on the easily mobile diaphragm and coupled abdominal organs. Being mobile, with the air of the lungs on one side and the soft abdominal wall on the other, this thoraco-abdominal system is easily set in motion by lower energy (amplitude) vibrations than are required to perturb other parts of the body.⁵¹ Each part of the body has its own resonance frequency with regard to vibration. When an object is vibrated at its resonance frequency, the vibration is amplified. The resonant frequency of the thoraco-abdominal system, as it moves vertically towards and away from the lungs, lies between 4 and 8 Hz for adult humans.⁵² Vibrations between 4 and 6 Hz set up resonances in the trunk with amplification up to 200%.⁵³ Related chest and abdominal effects are found in the same frequency range. Vibrations in the 4-8 Hz range influence breathing movements, 5-7 Hz can cause chest pains, 4-10 Hz abdominal pains, and 4-9 Hz a general feeling of discomfort.⁵⁴ In small children under 40 pounds, the vertical resonance or power absorption peaks at 7.5 Hz, as opposed to 4-5 Hz for adults.⁵⁵

Low frequency noise can cause the human body to vibrate, as quantified by researchers in Japan.⁵⁶ The degree to which the body surface is induced to vibrate by low frequency noise is correlated with subjective unpleasantness (a sensation suggesting visceral as well as surface/somatic stimulation by the noise).⁵⁷

With this background, I hypothesize the following mechanism for VVVD. Air pressure fluctuations in the range of 4-8 Hz, which may be harmonics of the turbine blade passing frequency, may resonate (amplify) in the chest and be felt as vibrations or quivering of the diaphragm with its attached abdominal organ mass (liver). Slower air pressure fluctuations, which could be the blade passing frequencies themselves or a low harmonic (1-2 Hz), would be felt as pulsations, as opposed to the faster vibrations or quivering. (The vibrations or pressure fluctuations may also be occurring at different frequencies, without resonance amplification.) The pressure fluctuations in the chest could disturb visceral receptors, such as large vessel or pulmonary baroreceptors or mediastinal stretch receptors, which function as visceral

⁵¹ Coermann RR, Ziegenruecker GH, Wittwei AL, von Gierke HE. 1960. The passive dynamic mechanical properties of the human thorax-abdominal system and of the whole body system. *Aerospace Medicine* 31(6): 443-55.

⁵² von Gierke and Parker 1994

⁵³ Hedge, Alan, 2007

⁵⁴ Rasmussen 1982

⁵⁵ Giacomini J. 2005. Absorbed power of small children. *Clin Biomech* 20(4): 372-80.

⁵⁶ Takahashi Y, Yonekawa Y, Kanada K, Maeda S. 1999. A pilot study on the human body vibration induced by low-frequency noise. *Industrial Health* 37: 28-35.

⁵⁷ Takahashi Y, Kanada K, Yonekawa Y, Harada N. 2005. A study on the relationship between subjective unpleasantness and body surface vibrations induced by high-level low-frequency pure tones. *Industrial Health* 43: 580-87, p. 580.

graviceptors. These aberrant signals from the visceral graviceptors, not concordant with signals from the other parts of the motion-detecting system, have the potential to activate the integrated neural networks which link motion detection with somatic and autonomic outflow, emotional fear responses, and aversive learning. The people who are susceptible to responding in this way are those who in the past have become nauseated in response to other vertically oriented, anomalous environmental movements (seasickness or carsickness). Thus panic episodes with autonomic symptoms such as tachycardia and nausea arise during wakefulness or sleep in people with pre-existing motion sensitivity but without prior history of panic, anxiety, or other mental health disorders. Repeated triggering of these symptoms creates aversive learning, wherein the person begins to feel horror and dread of things associated with the physical sensations, such as his bedroom or house where he previously found comfort and regeneration.

VVVD was identified in the study in 14 out of 21 adult subjects. The behavior and experiences of other subjects, especially children, could be interpreted as partial manifestations of the same problem. For example, the two toddlers in the study, both aged 2½ (A3, G5), had night terrors. They awoke screaming multiple times per night, and were inconsolable and difficult to get back to sleep. The little girl (G5) would fight her mother, grabbing onto the posts of the bunk bed, to avoid going back into her own bed after awakening in this state. This shows clear parallels with the fear responses, prolonged awake periods, and aversive responses of the adults with VVVD. Both toddlers were agitated and irritable in the daytime, also similar to the adults in the study. Both 5-year-olds in the study, a boy and a girl (C7, G4), also frequently woke up fearful at night.

Perturbing the inner ear

I propose that disrupted stimulation of other channels of the balance system, especially the inner ear vestibular organs, is also likely to play a role in Wind Turbine Syndrome. Altogether, in subjects with or without VVVD, the Wind Turbine Syndrome core symptoms resemble the symptoms of a balance or vestibular disorder, meaning malfunctioning of the inner ear motion-detecting organs (peripheral vestibular dysfunction) or of brain processing of balance-related neural signals (central balance dysfunction). Near wind turbines, I suggest that these symptoms may arise through disturbed input to the classical pathways of motion and position perception (the visual, vestibular, and somatosensory channels), perhaps in an additive fashion. If several pathways are abnormally stimulated at the same time, it becomes even more likely that multisensory vestibular brain centers⁵⁸ will receive disordered or

⁵⁸ Dieterich M, Brandt T. 2008. Functional brain imaging of peripheral and central vestibular disorders. Brain, E-pub ahead of print, May 30, 2008, pp. 1-15.

including humans. These structures are used by fish (like us) to sense acceleration and tilt relative to gravity, but also to detect nearby perturbations in the water ("near-field sound") with peak sensitivities in the low frequency range between 40 and 120 Hz.⁶⁶ Certain fish are also known to detect distant low-frequency sound, which they use to navigate relative to distant shores where waves are breaking.⁶⁷

Most exciting, new research provides direct experimental evidence that normal human vestibular organs are sensitive to low-frequency vibration (which is the same as bone-conducted sound) and *much more sensitive than the cochlea*.⁶⁸ Among normal subjects, this sensitivity is "tuned" (has a sharp peak of sensitivity and response) at 100 Hz (G-G# 1½ octaves below middle C, keys 23-24 on a piano). Researchers applied carefully calibrated force and vibration frequency directly to the bony mastoid prominence behind the subjects' ears. They were able to elicit and measure responses of the vestibulo-ocular reflex at vibration intensities 15 dB below the subjects' hearing thresholds. In other words, the subjects could no longer hear the bone-conducted sound created by applying vibration to their mastoids, but the vestibular parts of the inner ear still picked up the vibration and transmitted signals into the balance and motion networks in the brain, resulting in specific types of eye muscle activation. Since dB is a base 10 logarithmic measure, 15 dB below means a signal 0.0316 ($10^{-1.5}$), or about 3%, of the power or amplitude of the signal these normal subjects could hear.

The researchers note that "the very low thresholds we found are remarkable as they suggest that humans possess a frog- or fish-like sensory mechanism which appears to exceed the cochlea for detection of substrate-borne low-frequency vibration and which until now has not been properly recognized."⁶⁹ Thus the potential exists, in normal humans, for stimulation and disruption of balance signals from the inner ear by low-frequency noise and vibration, even when the noise or vibration does not seem especially loud.

Central balance processing

When there is conflict in healthy people among the signals coming from the different balance channels, the brain areas that integrate the information quickly compensate by suppressing or down-weighting the anomalous channel.⁷⁰ On functional brain scans, vestibular and visual cortical areas show a pattern of

⁶⁶ Fay RR, Simmons AM. 1999. The sense of hearing and fishes and amphibians. In *Comparative Hearing: Fish and Amphibians*, ed. Fay RR, Popper AN, pp. 269-317. Springer-Verlag, New York.

⁶⁷ Sand O, Karlsen HE. 1986. Detection of infrasound by the Atlantic cod. *J Exp Biol* 125: 197-204.

⁶⁸ Todd NPMc, Rosengren SM, Colebatch JG. 2008. Tuning and sensitivity of the human vestibular system to low-frequency vibration. *Neuroscience Letters* 444: 36-41.

⁶⁹ Todd et al. 2008, p. 41.

⁷⁰ Jacob RG, Redfern MS, Furman JM. 2008. Space and motion discomfort (SMD) and abnormal balance control in patients with anxiety disorders. *J Neurol Neurosurg Psychiatry*, E-pub ahead of print, July 24, 2008, pp. 1-20.

inverse activation and deactivation, such that vestibular activation deactivates visual cortex and vice versa.^{71,72} In people with vestibular organ damage, long-term compensation promotes reliance on vision ("visual dependence") or on somatosensory input from muscles, tendons, joints, and skin ("surface dependence"). A visually dependent vestibular patient cannot adequately suppress visual input and up-weight vestibular signals because of pre-existing problems with the vestibular channel,⁷³ leaving the person dependent on visual perception of motion and position even in environments where the visual information is ambiguous. This can create fear of heights. It can also cause Space and Motion Discomfort,⁷⁴ a condition of discomfort in situations challenging to motion and position sense such as looking up at tall buildings, scanning shelves in a supermarket, closing eyes in the shower, leaning far back in a chair, driving through tunnels, riding in an elevator, riding in the back seat of a car, or reading in the car.⁷⁵

Even without vestibular organ disease, some people have Space and Motion Discomfort due to central (brain) difficulty integrating balance signals into a coherent, moment-to-moment internal representation of position and motion. Balance testing with posturography shows that such people have difficulty down-weighting anomalous information from either the visual or somatosensory channel, or have a mild, central disorder of balance control with increased postural sway even under non-challenging conditions.^{76,77,78}

Space and Motion Discomfort is common in patients with anxiety disorders,^{79,80} migrainous vertigo,⁸¹ and migraine-anxiety related dizziness.⁸² Vertigo is especially characteristic of migraine and may at times occur as a migraine aura with or without headache.⁸³ In one study, dizziness or vertigo was found in 54%

⁷¹ Brandt T, Bartenstein P, Janek A, Dieterich M. 1998. Reciprocal inhibitory visual-vestibular interaction. Visual motion stimulation deactivates the parieto-insular vestibular cortex. *Brain* 121(Pt. 9): 1749-58.

⁷² Brandt T, Dieterich M. 1999. The vestibular cortex: its locations, functions, and disorders. *Ann NY Acad Sci* 871: 293-312.

⁷³ Redfern MS, Yardley L, Bronstein AM. 2001. Visual influences on balance. *J Anxiety Disord* 15(1-2): 81-94.

⁷⁴ Jacob RG, Woody SR, Clark DB, Liliensfeldt SO, Hirsch BE, Kucera GD, Furman JM, Durrant JD. 1993. Discomfort with space and motion: a possible marker of vestibular dysfunction assessed by the Situational Characteristics Questionnaire. *J Psychopathol Behav Assess* 15(4): 299-324.

⁷⁵ Jacob RG, Redfern MS, Furman JM. 2008. Space and motion discomfort (SMD) and abnormal balance control in patients with anxiety disorders. *J Neurol Neurosurg Psychiatry*, E-pub ahead of print, July 24, 2008, pp. 1-20. As a rural physician, I might also ask about driving past rows of parallel trees, especially with the low winter sun flashing between the trunks, as the rural equivalent of looking at lights on the wall of a tunnel.

⁷⁶ Redfern MS, Furman JM, Jacob RG. 2007. Visually induced postural sway in anxiety disorders. *J Anxiety Disord* 21(5): 704-16. NIH Public Access Author Manuscript, pp. 1-14.

⁷⁷ Jacob et al. 2008

⁷⁸ Furman JM, Balaban CD, Jacob RG, Marcus DA. 2005. Migraine-anxiety related dizziness (MARD): a new disorder? *J Neurol Neurosurg Psychiatry* 76: 1-8.

⁷⁹ Jacob et al. 2008

⁸⁰ Redfern et al. 2007

⁸¹ Neuhauser H, Leopold M, von Brevern M, Arnold G, Lempert T. 2001. The interactions of migraine, vertigo, and migrainous vertigo. *Neurology* 56: 436-41.

⁸² Furman et al. 2005

⁸³ Furman et al. 2005

of 200 migraine patients, half of whom also had a history of motion sickness, compared with 30% of those with tension-type headaches.⁸⁴ In a study of 72 patients with isolated recurrent vertigo, 61% were found to have migraine, compared to 10% in a control group of orthopedic patients.⁸⁵ Abnormal balance testing is seen in patients with migraine but not in those with tension-type headaches.⁸⁶ Balance testing shows that both peripheral and central balance abnormalities exist in migraine patients, both more prominent if dizziness or vertigo is an associated symptom.⁸⁷

The dizziness associated with anxiety is not necessarily created by the anxiety, as is often assumed, but may have a component of disturbed balance control.^{88,89} For example, the presence of panic or fear of heights is significantly associated with abnormalities on vestibular caloric testing.⁹⁰ A positive questionnaire for Space and Motion Discomfort is significantly associated with abnormalities on posturography showing either surface⁹¹ or visual⁹² dependence. In other types of balance testing, anxiety patients have been found to have greater vestibular sensitivity than normal controls.⁹³ Balance assessments of patients diagnosed with panic attacks or agoraphobia (fear of leaving the house) show a high proportion with vestibular abnormalities, in some studies greater than 80%, especially if the patients have episodes of dizziness between panic attacks.^{94,95,96,97}

If a person is already in a state of adaptation to ongoing vestibular or central balance deficits – even mild, fully compensated deficits – he or she is at particular risk for decompensation with exposure to new balance challenges. Many of the affected people in the present study, I suspect, were in this condition, because their medical histories reveal a variety of risks for mild baseline balance dysfunction. These risks include motion sensitivity, migraine disorder, prior damage to inner ear organs from industrial noise

⁸⁴ Kayan A, Hood JD. 1984. Neuro-otological manifestations of migraine. *Brain* 107: 1123-42.

⁸⁵ Lee H, Sohn SI, Jung DK, Cho YW, Lim JG, Yi SD, Yi HA. 2002. Migraine and isolated recurrent vertigo of unknown cause. *Neurol Res* 24(7): 663-5.

⁸⁶ Ishizaki K, Mori N, Takeshima T, Fukuhara Y, Ijiri T, Kusumi M, Yasui K, Kowa H, Nakashima K. 2002. Static stabilometry in patients with migraine and tension-type headache during a headache-free period. *Psychiatry Clin Neurosci* 56(1): 85-90.

⁸⁷ Furman et al. 2005

⁸⁸ Furman et al. 2005

⁸⁹ Eckhardt-Henn A, Breuer P, Thomäcke C, Hoffmann SO, Hopf HC. 2003. Anxiety disorders and other psychiatric subgroups in patients complaining of dizziness. *J Anxiety Disord* 17(4): 369-88.

⁹⁰ Jacob et al. 2008

⁹¹ Jacob et al. 2008

⁹² Redfern et al. 2007

⁹³ Furman JM, Redfern MS, Jacob RG. 2006. Vestibulo-ocular function in anxiety disorders. *J Vestib Res* 16: 209-15.

⁹⁴ Perna G, Dario A, Caldirola D, Stefania B, Cesarani A, Bellodi L. 2001. Panic disorder: the role of the balance system. *J Psychiatr Res* 35(5): 279-86.

⁹⁵ Jacob RG, Furman JM, Durrant JD, Turner SM. 1996. Panic, agoraphobia, and vestibular dysfunction. *Am J Psychiatry* 153(4): 503-12.

⁹⁶ Yardley L, Britton J, Lear S, Bird J, Luxon LM. 1995. Relationship between balance system function and agoraphobic avoidance. *Behav Res Ther* 33(4): 435-9.

⁹⁷ Yardley L, Luxon LM, Lear S, Britton J, Bird J. 1994. Vestibular and posturographic test results in people with symptoms of panic and agoraphobia. *J Audiol Med* 3: 58-65.

exposure or chemotherapy, autoimmune disease,⁹⁸ fibromyalgia,⁹⁹ normal aging (over 50), and normal early childhood.^{100,101} Other potential risks for chronic vestibular dysfunction are whiplash injury and head injury, including concussions and milder head impacts without loss of consciousness.^{102,103,104}

Cognition and vestibular function

It is now becoming apparent that a variety of cognitive functions depend on coherent vestibular signaling. Clinicians who work with balance-disordered patients are familiar with their struggles with short-term memory, concentration, multitasking, arithmetic, and reading.^{105,106} In the perilymphatic fistula syndrome, for example (a form of inner ear pathology that can follow whiplash, minor head injuries, or pressure trauma to the ear), symptoms of dizziness, headache, stiff neck, and disturbed sleep are accompanied by marked mental performance deficiencies compared to the patient's baseline.¹⁰⁷ Such cognitive symptoms are difficult to evaluate clinically and are often dismissed as psychological in origin.¹⁰⁸ However, recent research using imaging and other modalities shows that vestibular function exerts a powerful influence over human thinking and memory.

The vestibular system is ancient in the vertebrate lineage (as reviewed above). Its neural connections ramify widely in both older and more recently evolved parts of the brain, including the brainstem, midbrain, cerebellum, and occipital, parietal, and frontal cortex.¹⁰⁹ Vestibular injury causes specific deficits, but not general cognitive impairment.¹¹⁰ Vestibular effects on cognition are often attributed to competing stimuli (meaning challenges to movement and position sense draw attention away from

⁹⁸ Rinne T, Bronstein AM, Rudge P, Gresty MA, Luxon LM. 1998. Bilateral loss of vestibular function: clinical findings in 53 patients. *J Neurol* 245(6-7): 314-21.

⁹⁹ Rosenhall U, Johansson G, Orndahl G. 1996. Otoneurologic and audiologic findings in fibromyalgia. *Scand J Rehabil Med* 28(4): 225-32.

¹⁰⁰ Foudriat BA, Di Fabio RP, Anderson JH. 1993. Sensory organization of balance responses in children 3-6 years of age: a normative study with diagnostic implications. *Int J Pediatr Otorhinolaryngol* 27(3): 255-71.

¹⁰¹ Steindl R, Kunz K, Schrott-Fischer A, Scholtz AW. 2006. Effect of age and sex on maturation of sensory systems and balance control. *Dev Med Child Neurol* 48(6): 477-82.

¹⁰² Grimm RJ, Hemenway WG, Lebray PR, Black FO. 1989. The perilymph fistula syndrome defined in mild head trauma. *Acta Otolaryngol Suppl* 464: 1-40.

¹⁰³ Ernst A, Basta D, Seidl RO, Todt I, Scherer H, Clarke A. 2005. Management of posttraumatic vertigo. *Otolaryngol Head Neck Surg* 132(4): 554-8.

¹⁰⁴ Claussen CF, Claussen E. 1995. Neurootological contributions to the diagnostic follow-up after whiplash injuries. *Acta Otolaryngol Suppl* 520, Pt. 1: 53-6.

¹⁰⁵ Hanes and McCollum 2006

¹⁰⁶ Grimm et al. 1989

¹⁰⁷ Grimm et al. 1989

¹⁰⁸ Hanes and McCollum 2006

¹⁰⁹ Dieterich and Brandt 2008

¹¹⁰ Hanes and McCollum 2006

cognitive tasks) but may actually reflect, instead, the direct dependence of certain cognitive operations on the vestibular system.¹¹¹

Vestibular input is critical for spatial thinking, body and spatial awareness, spatial memory, and complex spatial or map calculations.¹¹² Dynamic, active vestibular signaling is needed for the acquisition, storage, and use of information with spatial components, such as building mental maps or deducing a novel path between two points.¹¹³ Patients with 5-10 year histories of bilateral vestibular loss showed marked deficits in a classic experimental task of spatial memory and navigation, accompanied, on average, by a 16.9% volume loss in the hippocampus (a temporal lobe structure essential for learning and memory).¹¹⁴ In a test of general memory, however, these patients were no different from controls.¹¹⁵ Vestibular signaling to the hippocampus is known to occur in both humans and other primates via a direct, two-neuron linkage through the posterior thalamus; there are also other proposed neural pathways.¹¹⁶

Disordered vestibular input increases error rates in purely mental tasks based on visualization of remembered objects, showing that coherent vestibular input is critical for thinking successfully and efficiently in spatial terms.¹¹⁷ This is true even without using sight and beyond the period of memory storage. The tasks included detailed visualization, considered an occipital (visual) cortical task, and mental rotation, a parietal cortical task.¹¹⁸ Vestibular stimulation in both humans and other primates activates a variety of areas in the parietal cortex, including 1) a core vestibular processing area (posterior insula), 2) the somatosensory strip, 3) areas involved in hemineglect in stroke patients (ventral parietal), 4) and a region "known to be involved in multimodal coordinate transformations and representation of space" (intraparietal sulcus), which is a principal site for arithmetic and counting tasks.¹¹⁹ Hemineglect is a condition after right-sided parietal stroke in which a patient can have so much unawareness of the left side of space that he is oblivious to his own left-sided body parts being paralyzed, for example, or undressed. Vestibular stimulation temporarily corrects or improves this unawareness, in ways that suggest stimulation not only to general attention, but also to cerebral structures involved in the mental

¹¹¹ Hanes and McCollum 2006

¹¹² Hanes and McCollum 2006

¹¹³ Brandt T, Schautzer F, Hamilton DA, Bruning R, Markowitsch HJ, Kalla R, Darlington C, Smith P, Strupp M. 2005. Vestibular loss causes hippocampal atrophy and impaired spatial memory in humans. *Brain* 128: 2732-41.

¹¹⁴ Brandt et al. 2005

¹¹⁵ Brandt et al. 2005

¹¹⁶ Brandt et al. 2005

¹¹⁷ Mast FW, Merfeld DM, Kosslyn SM. 2006. Visual mental imagery during caloric vestibular stimulation. *Neuropsychologia* 44(1): 101-9. I wonder whether the detailed visualization task also included a parietal component, given the quantitative comparison the subjects had to make with the remembered image.

¹¹⁸ Mast et al. 2006. I wonder whether the detailed visualization task also included a parietal component, given the quantitative comparison the subjects had to make with the remembered image.

¹¹⁹ Hanes and McCollum 2006, p. 82.

representation of space.^{120,121} Vestibular stimulation also improves hemineglect patients' performance on tasks of visual localization and visual-spatial memory retrieval. At baseline, and again 24 hrs after the experiment, their responses were biased away from the left side, but this bias was corrected or improved immediately after left vestibular stimulation.¹²²

Studies of hemineglect patients have further shown that many mental operations are "spatialized" and dependent on parietal brain areas that have been lost, including mathematical operations involving a "mental number line" with lower numbers on the left,^{123,124} clock representations of time,¹²⁵ and spelling at the beginnings (left) or ends (right) of words (errors occur opposite to the side of the parietal lesion).¹²⁶ In right-handed patients with right parietal strokes, there is no impairment to simple numeric calculation (a left-sided parietal function), but there is impairment to spatialized mathematical thinking, such as finding the midpoint between two numbers.¹²⁷ At the other extreme of mental functioning, it has been found that great mathematicians think of numbers in spatial terms,¹²⁸ which "may be more efficient because it is grounded in the actual neural representation of numbers."¹²⁹ A recent study of outstanding human memorizers shows that spatially oriented strategies are also critical to good memory, by providing an efficient framework for memory organization and retrieval.¹³⁰

In summary, coherent vestibular neural input is critical for spatialized forms of thinking and memory. Spatialized thinking and memory is intrinsic to many of the things we do with our minds, including mathematical thinking and memory organization (as discussed above) and many forms of map-based or visually based problem-solving or short-term memory we do in everyday life. Spatial thinking is used, for example, to figure out the most efficient path for a set of errands, remember the path and images of the items to be obtained, search for the items on the shelf, and judge if one was given the correct change. It is used for mental "maps" or calendars of one's day, week, or month and its appointments, to picture in three dimensions how to put something together, or imagine what has gone wrong inside a device and initiate a

¹²⁰ Geminiani G, Bottini G. 1992. Mental representation and temporary recovery from unilateral neglect after vestibular stimulation. *J Neurol Neurosurg Psychiatry* 55(4): 332-3.

¹²¹ Cappa S, Sterzi R, Vallar G, Bisiach E. 1987. Remission of hemineglect and anosognosia during vestibular stimulation. *Neuropsychologia* 25: 775-82.

¹²² Geminiani and Bottini 1992

¹²³ Zorzi M, Piffrin K, Umiltà C. 2002. Brain damage: Neglect disrupts the mental number line. *Nature* 417: 138-9.

¹²⁴ Vuilleumier P, Ortigue S, Brugger P. 2004. The number space and neglect. *Cortex* 40(2): 399-410.

¹²⁵ Vuilleumier et al. 2004

¹²⁶ Hillis HE, Caramazza A. 1995. Spatially specific deficits in processing graphemic representations in reading and writing. *Brain Lang* 48 (3): 263-308.

¹²⁷ Zorzi et al. 2002

¹²⁸ Hadamard J. 1996. *The Mathematician's Mind: The Psychology of Invention in the Mathematical Field*. Princeton University Press, NJ. In Zorzi et al. 2002.

¹²⁹ Zorzi et al. 2002

¹³⁰ Maguire EA, Valentine ER, Wilding JM, Kapur N. 2003. Routes to remembering: the brains behind superior memory. *Nat Neurosci* 6(1): 90-5.

repair. It is used for understanding the images in a movie or TV show with the sensitivity not to miss subtle visual clues. In this context, it is easy to see how vestibular disturbance could impact concentration (which means the ability to perform thinking tasks successfully and efficiently) and memory. Vestibular disturbance also has the potential to affect reading directly via the reflex control exerted by semicircular canal and otolith organs over eye movements (vestibulo-ocular reflex).

Effects on concentration and memory were nearly ubiquitous in the present study, if one includes all subjects that told me about any problem in this area. For some subjects the deficits were dramatic compared to baseline (before exposure), including the 7 out of 10 school-age children and teens who showed a decline in their academic performance. Detrimental effects on concentration and memory were significantly associated with normal memory at baseline ($p = 0.027$) and with fatigue and loss of energy and motivation during exposure ($p = 0.018$). Though sleep deprivation and disturbance undoubtedly play a role, qualitative aspects of the mental performance deficiencies suggests a mechanism other than sleep disturbance alone. I propose that this mechanism is the effect of vestibular disturbance on cognition.

It is interesting here to examine a possible role of vestibular disturbance in the learning of very young children, in the toddler and preschool years. Mrs. G. (G2) volunteered that her 2½-year-old's (G5) irritability during turbine exposure was especially triggered by her older siblings' "unsteadying her" or coming so close that she thought she might be unsteadied. Children at this age are learning to keep their balance through a variety of different kinds of activities and postures. They are both fascinated and relaxed by vestibular stimulation (swinging, spinning, rolling, somersaults, etc.) and they actively explore the physical world through this play. The behavior of objects in gravity is another source of fascination, starting with babies' casting behavior and moving on to pouring water, sliding down slides, rolling things down inclines, building dams, floating toy boats, blowing bubbles, releasing helium balloons, etc. Vestibular input and processing play a critical role in balance during movement; in the generation, storage, and use of internal maps; and in recognition of the behavior of objects under the influence of gravity. Indovina et al. measured brain activity by functional MRI while adult subjects watched the movement of simulated objects, finding that the vestibular network was selectively engaged when the acceleration of the object was consistent with natural gravity, even though the stimulus was only visual.¹³¹ The authors use this as evidence that "predictive mechanisms of physical laws of motion are represented in the human brain"¹³² under the influence of vestibular signaling of the vector of gravity. I suggest that these representations of the physical laws of motion are embedded in the human brain during early

¹³¹ Indovina I, Maffei V, Bosco G, Zago M, Macaluso E, Lacquaniti F. 2005. Representation of visual gravitational motion in the human vestibular cortex. *Science* 308: 416-9.

¹³² Indovina et al. 2005

childhood as toddlers and children learn through experimentation (play) about the behavior of their bodies and other objects in gravity, and that coherent vestibular signaling is critical to this learning.

Environmental noise, learning, sleep, and health effects

Many studies have quantified the effects of environmental noise on children's learning. Reading acquisition – a language-intensive process – is especially sensitive to the effects of noise in school and at home. The effect is distinct from the effects of noise on attention or working memory,¹³³ and is correlated with measures of language processing such as speech recognition.¹³⁴ Airplane noise, which has a large low frequency component, has a stronger effect than traffic noise in some studies,¹³⁵ but traffic noise is also shown to have modest effects on memory in quieter communities.¹³⁶ Most studies are cross-sectional, but a longitudinal or cohort study, done when an airport was closed in one location and opened in another, showed similar effects on reading acquisition.¹³⁷ One study showed effects of noise on reading and auditory processing in children who lived in an apartment building next to a busy highway. The higher they lived in the building, the quieter were their apartments and the better their reading and auditory discrimination scores (e.g., distinguishing *goat* from *boat*). After controlling for parental education and income, the auditory discrimination scores largely explained the noise-reading linkage.¹³⁸ These effects on reading occur at sound levels far less than those needed to produce hearing damage.¹³⁹ Children with pre-existing reading deficiencies and children at higher grade levels are more affected, and longer exposure produces larger deficits.¹⁴⁰

Effects suggestive of wind turbine noise impact on auditory discrimination or central auditory processing were found in the current study. During the period immediately after moving away from turbines and the cessation of her tinnitus, Mrs. A (A2, age 33) found she had a new difficulty understanding conversation

¹³³ Haines MM, Stansfeld SA, Job RFS, Berglund B, Head J. 2001. A follow-up study of effects of chronic aircraft noise exposure on child stress responses and cognition. *International Journal of Epidemiology* 30: 839-45.

¹³⁴ Evans GW, Maxwell L. 1997. Chronic noise exposure and reading deficits: the mediating effects of language acquisition. *Environment and Behavior* 29(5): 638-56.

¹³⁵ Clark C, Martin R, van Kempen E, Alfred T, Head J, Davies HW, Haines MM, Barrio IL, Matheson M, Stansfeld SA. 2005. Exposure-effect relations between aircraft and road traffic noise exposure at school and reading comprehension: the RANCH project. *Am J Epidemiol* 163: 27-37.

¹³⁶ Lercher P, Evans GW, Meis M. Ambient noise and cognitive processes among primary schoolchildren. *Environment and Behavior* 35(6): 725-35.

¹³⁷ Hygge S, Evans GW, Bullinger M. 2002. A prospective study of some effects of aircraft noise on cognitive performance in schoolchildren. *Psychol Sci* 13: 469-74.

¹³⁸ Cohen S, Glass DC, Singer JE. 1973. Apartment noise, auditory discrimination, and reading ability in children. *Journal of Experimental Social Psychology* 9: 407-22.

¹³⁹ Evans GW. 2006. Child development and the physical environment. *Annu Rev Psychol* 57: 423-51.

¹⁴⁰ Evans 2006, p. 426.

superficial. The results also suggest that the health status sampling was inadequate. For example, the study found that only 2% of respondents indicated they had chronic migraine disorder,¹⁸⁹ whereas the population prevalence is probably 12-13%. Likewise, tinnitus prevalence in this study was 2%, whereas 4% is a more likely population figure for the average age of 54.¹⁹⁰ Tinnitus prevalence was not correlated with age in this sample,¹⁹¹ while in reality tinnitus has a well-documented pattern of increasing prevalence with advancing age.¹⁹² In sum, this survey did not adequately sample health status, and was not designed with comparison groups so as to detect differences.

Recommendations

For physicians practicing near wind turbine installations, I suggest incorporating proximity to turbines into the personal and social history in a neutral and non-suggestive way, especially for the types of symptoms described in this report.

With regard to turbine setback from dwellings: In Table 1B we see that the subjects in the current study lived between 305 m (1000 ft) and 1.5 km (4900 ft or 0.93 mi) from the closest turbine. There were three severely affected families at 930-1000 m (3000-3300 ft) from turbines. This study suggests that communities that allow 1000-1500 ft (305-457 m) setbacks from houses may have families who need to move after turbines go into operation. All turbine ordinances, I believe, should establish mechanisms to ensure that turbine developers will buy out any affected family at the full pre-turbine value of their home, so that people are not trapped between unlivable lives and destitution through home abandonment. By shifting the burden of this expense to turbine developers, I would hope that developers might have a stronger incentive to improve their techniques for noise prediction and to accept noise level criteria recommended by such agencies as the World Health Organization and the International Standards Organization,¹⁹³ and fortified by the findings of Pedersen and van den Berg (above). With regard to families already affected, developer and permitting agencies share the responsibility for turbines built too close to homes, and together need to provide the financial means for these families to reestablish their lives at their previous level of health, comfort, and prosperity.

¹⁸⁹ van den Berg et al. 2008b, p. 48.

¹⁹⁰ National Institute on Deafness and Other Communication Disorders, USA, website, "Prevalence of Chronic Tinnitus." 2009. <http://www.nidcd.nih.gov/health/statistics/prevalence.htm>

¹⁹¹ van den Berg et al. 2008b, p. 47.

¹⁹² National Institute on Deafness and Other Communication Disorders, USA, website, "Prevalence of Chronic Tinnitus." 2009. <http://www.nidcd.nih.gov/health/statistics/prevalence.htm>

¹⁹³ See George Kamperman and Richard James, *The "How To" guide to siting wind turbines to prevent health risks from sound*, 47 pp., at <http://www.windturbinesyndrome.com/?p=925> (2008).

I support the recommendations for noise level criteria and procedures for noise monitoring by George Kamperman and Richard James.¹⁹⁴ A single setback distance may not be both protective and fair in all environments with all types of turbines, but it is clear, from the current study and others, that minimum protective distances need to be more than the 1-1.5 km (3280-4900 ft or 0.62-0.93 mi) at which there were severely affected subjects in this study, more than the 1.6 km (5250 ft or 1 mi) at which there were affected subjects in Dr. Harry's UK study,¹⁹⁵ and, in mountainous terrain, more than the 2-3.5 km (1.24-2.2 mi) at which there were symptomatic subjects in Professor Robyn Phipps's New Zealand study.¹⁹⁶ Two kilometers, or 1.24 miles, remains the baseline shortest setback from residences (and hospitals, school, nursing homes, etc.) that communities should consider. In mountainous terrain, 2 miles (3.2 km) is probably a better guideline. Setbacks may well need to be longer than these minima, as guided by the noise criteria developed by Kamperman and James.

Suggestions for further research

- Epidemiologic studies comparing populations exposed and not exposed to wind turbines with regard to the prevalence of specific symptoms, such as tinnitus and balance disorders. Such studies might be best conducted in European countries that have both national health data systems and significant numbers of wind turbines.
- Case series by neurologists internationally, who are able to do appropriate objective examination and testing in addition to clinical history.
- Collaboration between physicians and independent noise engineers to correlate specific frequencies and intensities of sound and vibration with subjects' symptoms, and to establish a standard protocol for noise sampling that captures the elements relevant to health effects.
- Further clinical/laboratory research on the effects of low frequency noise and vibration on the human vestibular system.

¹⁹⁴ Kamperman GW, James RR, *The "How To" guide to siting wind turbines to prevent health risks from sound*, 47 pp., at <http://www.windturbinesyndrome.com/?p=925> (2008). Presented in shorter form, Kamperman GW, James RR, "Simple guidelines for siting wind turbines to prevent health risks," at the annual conference of the Institute of Noise Control Engineering/USA, Noise-Con, July 28-31, 2008.

¹⁹⁵ Harry, Amanda, 2007.

¹⁹⁶ Phipps, Robyn, 2007.