

atmosphere of equanimity is in part attributable to the program director, a down-home, spitfire Southern woman with an endless supply of energy and resourcefulness. Although Pamela Washbourne stands barely over five feet tall, she commands reverence and adoration from staff and patients alike, resulting in a tremendous sense of loyalty and family on the unit, a dynamic difficult to duplicate in larger environments. Charisma aside, it is Pam's innovative approach to neuro-behavioral treatment that prompts phone calls from incredulous rehab professionals all over the nation. She claims her secret is simple: let the patient teach you what he needs.

Once you arrive on the unit, you're in a completely different world without realizing it. Every externality is a suspected triggering device for unpredictable behavior. The way a particular vent rattles when the air blows may sound like a jet engine to one patient. Another patient might have such overstimulated tactile sensation that a warm shower feels like a spray of needles. It takes the treatment team weeks of intense observation to figure out each patient's particular triggers, and the solution typically involves an alteration of the environment. Depending on the combination of patients, we have dispensed with doorknobs, worn raingear indoors, removed all unanchored objects, and carried kick-boxing pads as protection. Creativity yields uncommon outcomes, my boss likes to say.

Brain injury rehabilitation occurs at a snail's pace, and it works by maintaining a militaristic adherence to consistency. The program is exactly the same every day. You shower, eat, and dress at the same time. There are no surprises and absolutely no deviations. If you're going to the grocery store, you know about and prepare for the trip days ahead of time. Whereas once your internal psychological world fluidly adapted to the world around you, now your outer

world must acquiesce to the demands of your impairments. Your new environment is meticulously ordered and rigid, a counterforce to the internal chaos of an injured brain. As uncomfortable and frustrating as the program must be for the patients, monotony and rhythm are fertile climes for the human brain.

In a best-case scenario, a patient comes to us in the throes of frustration, agitation, or psychosis, and over the course of several months, perhaps years, their unmanageable behaviors stabilize so that the potential for harm is diminished or eradicated. The patient then steps down from the intensive neurobehavioral unit and into one of our transitional living centers. Their time in a group home setting is a trial run for real-world reintegration. Most of the patients who succeed in transitional living are able to return either to their families or to appropriate housing in their home states. I have seen patients come to us demonstrating dozens of homicidal intents a day, only to be discharged back to their homes and into the workforce following their treatment.

The odds are slim that a caller will be accepted into NRI. Many of the beds are occupied for years at a time, as are many of the nation's brain injury beds. Only the most persistent and lucky caretakers get their patients accepted into NRI, but the majority of callers will be denied admission. That's where my real job starts. A person calls me looking for a bed, and I tell them we're full and that we have a waiting list. Without trying to sound the least bit hopeful, I ask for a name, date of injury, and an address. Although the caller is completely unaware of it, I'm asking myself if I need to visit the patient, and I'm mining my calendar to see when I'll be within a day's drive of their city. After taking a few notes I set my pen down and put a hand to my forehead. I lean a little into the receiver and I ask them to