

GROWTH POTENTIAL OF PRESCHOOL-AGED CHILDREN IN INSTITUTIONAL CARE:

A Positive Approach to a Negative Condition*

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A study of change of intellectual level in 132 "dependent and neglected" children aged two through seven. Significant gains in IQ are reported. Child care philosophy and methods in the Irvington House institutional program are documented. Possible implications of the study for child welfare are discussed.

INCREASINGLY in the past 25 years child welfare workers and theorists have frowned on institutional care for young children. Competent researchers have reported the debilitating effects of institutional care, with findings ranging from the irremediable, severe impairment of emotional and intellectual development reported by Bowlby¹ and Spitz^{7,8} to the seriously limited affect in later life reported by Goldfarb.²⁻⁶

Nevertheless, particularly since World War II, increasing numbers of children under the age of seven have been institutionalized for short or long periods.† Such placements have been considered

a necessary evil arising out of the shortage of foster homes, and, too often, we have reconciled ourselves to the theoretical assumption that children in institutions would inevitably suffer damage.

Partly as a result of this assumption, major professional emphasis has been on increasing the availability of foster homes, on improving foster home finding techniques, and on shortening the institutional stay of those young children for whom it is has been impossible to find other placements. There has been little emphasis on improving the quality of institutional care for these young children. The belief that institutional care

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†This has been particularly true in metropolitan areas where lack of facilities, either foster home or institutional, for "normal" dependent children has backlogged a number of children into so-called interim care where they "wait" for long-term planning.

as such is basically bad for young children has not been seriously questioned or evaluated in recent years. The concept that it may be the quality of care that affects the child's development, rather than whether the setting is institutional or foster home, has received little attention.

Our experience at Irvington House over a period of four and one-half years with group care of children between the ages of two and seven leads us to believe that institutional care, instead of being inevitably damaging to young children, can, on the contrary, be an experience in which growth is accelerated. The present study* attempts to investigate one aspect of this growth, namely, the relationship between institutional care and level of intellectual functioning. We hope to explore other aspects in subsequent papers.

BACKGROUND OF THE STUDY

Until May 1957, Irvington House was exclusively a research and treatment center for children with rheumatic fever. Because of the progressively shorter length of stay and the more rapid turnover of the children in the rheumatic fever program, the House had bed space available for other uses. Since Irvington House had always been as much a child care agency as a medical institution, and since New York City was desperately seeking interim care facilities for preschool children awaiting either foster home placement or return to temporarily disrupted natural families, it was decided to adapt the available space for an interim care program.

To safeguard the quality of the work, we have adhered rigidly to what we determined at that time to be our over-all capacity for this program. We have been flexible within limits with respect to the size of each living group, but have kept the original intention of consistently having no more than 50 children in the four dormitories regardless of the outside pressures.† Except for this capacity limitation, we have accepted all children referred and, except for a few seriously retarded children, have not rejected a child for "emotional cause." It seemed to us that if we were to give good interim care we must take a chance on the emotional status of the children who came and then gear ourselves to meet the needs of these children.

Since we were determined to provide a high degree of individualized care, it was obvious that the costs were likely to be high. For this as well as other reasons, it was decided to build at least a minimum of research into our efforts. We wanted to know whether the results were commensurate with the investment of money and staff time. We therefore incorporated into our psychological services a regular testing and retesting procedure. Each child is routinely tested for IQ shortly after admission, before discharge and also at nine-month intervals, if he remains at the House that long. Projective tests are used when indicated.

THEORETICAL AND PRACTICAL FRAMEWORK

Before the first child was admitted, planning was based on practical knowledge of the kinds of children we would

*The group included in this study comprises 132 children. From May 24, 1957, when the program began, through October 31, 1961, a total of 319 children were admitted. There are about 75 admissions a year.

†In October 1961 capacity was increased to 56 by setting up a fifth living group.

be admitting, the nature of our physical plant and certain theoretical assumptions about the needs of all children.

Although we would know little about the background and previous history of any particular child, most of the children could be expected to come from homes suffering from emotional, intellectual or physical deprivation, or a combination of all three. Moreover, in many cases placement would be traumatic, unplanned for, and with minimal preparation of the child. It seemed safe to assume that most of the children would have suffered emotional and intellectual damage because of the familial situations leading up to placement, and that in many cases the placement experience itself had caused further damage. Many would be coming from other shelters that were often large, overcrowded and unsuited to giving a particular child much individual attention.

Our physical plant is such that the 50 children were to be housed in four dormitories in groups of from 12 to 14 children. In the initial planning we considered trying to imitate some sort of family life, but quickly came to realize that this was not only impractical, but was probably undesirable and dishonest as well. Real families do not have 12 children within an age range of 18 months; they do not have fully grown children suddenly entering or being discharged; they do not usually consist of mixed groups of white, Negro and Puerto Rican children and they usually have only one mother and one father whose working day consists of many more hours than could be demanded even of the most dedicated staff. We have therefore been quite clear with ourselves, and we hope with the children, that Irvington House is a house, not a home, that

counselors are counselors, not parents, and that the other children in the dormitory are members of a group, not of a family.

Regardless of the setting, however, all small children have certain needs that must be met if they are to grow and prosper. For young children a paramount need is to feel that there is someone who really cares for him or her as an individual human being, someone with whom and for whom he is special. In addition to this special one-to-one relationship, the child must also feel that all, or most, of the people around him like and respect him for what he is. We have called this basic concept, along with the child-care practices that have grown out of it, "individualization." Since we make the basic theoretical assumption that damage to a child results whenever these needs are not met for any period of time, our goal has been to meet these needs within an institutional setting.

We assumed that small children need relatively small, self-contained settings for their basic physical care. Along with this they need the opportunity for privacy, some belongings which are their very own, some which are to be shared, and freedom to explore, within boundaries that set unobtrusive but firm limits on impulse.

A final assumption in relation to the program offered is that any positive life experience, no matter what its duration, strengthens the child in terms of meeting subsequent life experiences. When we were planning our program, the question was raised, only half jokingly, whether we would be "spoiling" the children. We were aware that many of them, on leaving Irvington House, would enter or re-enter situations offering less ade-

quate physical care, less intellectual stimulation, less consistency and, probably, a less stable emotional environment.

Quite aside from the fact that morally and professionally we are incapable of offering less than we have, our assumption is that if we offer the most we have, a child is better equipped to meet the vicissitudes of whatever his life may be when he leaves us.

Finally, it may be well to make explicit an assumption related to the specific IQ study reported here: The study is but one effort to evaluate the effectiveness of the Irvington House program of institutional care. While an IQ test by no means represents the entire spectrum of relevant variables, such sources, especially when repeated at standard intervals, provide a relatively objective measure of general developmental functioning. Particularly at the preschool ages, it would seem that decrease or increase in the child's IQ score would depend on his general emotional stability and comfortableness within the setting.

The result on a Stanford-Binet test can be considered a summary statement of general developmental functioning in many areas other than the purely intellectual.

ARRANGEMENTS WITHIN THIS FRAMEWORK

Although the children are by no means confined to their dormitories, these are relatively self-contained units with separate sleeping and playing quarters. This has facilitated the child's identification with his particular living group.

For the youngest group, two- and three-year-olds, we regularly scheduled

30 shifts a week of six staff members. The children in this group eat in a space adjacent to the dormitory; the older groups eat in our main dining room. For the three older units we regularly scheduled 20 shifts a week of four staff members.* This made it possible for each counselor to work not only with the group but also intensively with two or three children during the course of an eight-hour day of any five-day week. The purpose of the one-to-one relationship thus developed between counselor and child is to give the child a feeling that, despite some of the necessary impersonality and antiseptic quality of an institutional environment, someone on the staff cares for him or her as an individual human being above and beyond the requirements of the job. Individualization may take the form of a quiet time with the child, a shopping trip, a special trip to the city or a walk downtown. With more upset children it sometimes has involved elaborate arrangements allowing the child to test limits and build trust in an adult. Whatever the specific technique, sooner or later each child does develop a special relationship and will refer to a particular counselor as "my Charlotte" or, picking up our adult jargon, "my individual" or "my special."

The child-care staff is for the most part college-trained. The average age is 24. What we have looked for in staff is not so much specific experience as a kind of personality. We are particularly concerned to find people interested in and responsive to professional supervision. The child-care workers are directly supervised by trained group workers, with individual conferences as the

*As of the fall of 1961, this was increased to five staff members and 25 shifts.

main supervisory tool. We consider the child-care workers as professional people equal in status to the other professions with whom they work. In staff selection we look for people interested in eventually undertaking graduate training in social work or a related field and who will be, consequently, professionally as well as personally motivated.

As a matter of policy, we always have had at least one male worker assigned to each of the three older groups. In the beginning we were only able to have a man working with the two-year-olds during the summer, but for nearly two years now we have had a regular male worker even with this youngest group. We have tried consciously to keep the number of different adults with whom a child must have meaningful relationships to a minimum. Almost without exception, a child-care worker, once assigned to a given dormitory, has remained there throughout his employment at the House.

Each child has a social worker assigned to him, each worker having a case load of approximately 20 children. The degree of contact varies with the age and needs of the child.

Schooling is provided for the children either through our own nursery school or, if they are first graders or higher, through P.S. 403, the Irvington House facility for children with rheumatic fever. Except for the very youngest children in the two- or three-year-old group, all the children go to school. Nursery school is looked upon partly as an activity, partly as a means of allowing a child to work out his own emotional problems in a structured setting, partly

as a conscious effort to increase his range of experience and his knowledge of everyday life.*

In general, the institution as a whole attempts to provide an enriched program in which each child, supported by an intensified and personal relationship with at least one adult, can develop his interests and skills in an over-all friendly environment.

THE IQ STUDIES: SUBJECTS AND PROCEDURE

It is against this background that we have chosen to study changes in intellectual level during a child's stay at the institution. The 132 children included in the study represent nearly all children admitted to the institution since May 1957 and discharged before November 30, 1960. The exclusions are: children staying less than one month, those too disturbed for testing within the first month of their stay and those discharged too suddenly and abruptly to be examined. Children discharged between May and October 1957 were excluded because testing did not begin until September 1, 1957. There were 36 excluded in all—16 because of no initial score and 20 because they could not be tested before they left.

There were 69 boys and 63 girls ranging in age from two years and three months to seven years and eight months at date of first testing. Children were initially tested with the revised Stanford-Binet Scale (Form L). A Spanish-language edition of the test was used for Spanish-speaking children. The second testing took place about two weeks before discharge, or after a stay of nine

*The Irvington House nursery school is fully described in an article by Margaret Yonemura and Ruth Jones.¹⁰

months if the child was not yet scheduled to leave. On this occasion, Form M of the same scale was used. For the children discharged within nine months, the two scores represent the total data ($N = 94$). The children who remained longer than nine months were tested a third time with Form L, about two weeks before discharge ($N = 38$).

RESULTS

For the sake of statistical simplicity, the data were initially compared on a first-to-last test basis. These findings are presented below. TABLE 1 shows a mean initial IQ level of 89.0, a mean terminal level of 97.58, with a mean gain of 8.58

IQ points. The average interval between first and last tests for the 132 children was 8.72 months. Mean age of the group when first tested was 4.08 years.

The IQ increment for the total group is statistically significant at the 1 per cent level when the obtained results are tested against the hypothesis of a mean test-retest gain (experience factor) of 3 IQ points.⁹

TABLE 2 shows IQ change with respect to the length of time elapsed between first and last tests. This period represents approximately one month less than the total duration of stay of each child. There is an almost direct increase in positive IQ change with respect to duration of stay. IQ gains are statistically significant for all groups where the interval between tests was eight months or more. Among groups remaining more than 12 months there is no consistent increase in the magnitude of gain, indicating that the magnitude of increment may not continue the pattern of increasing in direct relation to duration of stay. For the present population, boys show slightly greater average increment than girls (9.44 IQ points as compared with 7.49 IQ points) and slightly greater gains than girls at almost all intervals.

TABLE 1

MEAN AGE WHEN FIRST TESTED, MEAN INTERVAL BETWEEN FIRST AND LAST TESTS, AND MEAN INITIAL AND TERMINAL IQ LEVELS

	<i>Boys</i>	<i>Girls</i>	<i>All subjects</i>
	<i>N=69</i>	<i>N=63</i>	<i>N=132</i>
	<i>Mean</i>	<i>Mean</i>	<i>Mean</i>
Age when first tested (in years)	3.99	4.17	4.08
Interval between first and last tests (in months)	8.76	8.66	8.72
Initial IQ	88.85	90.05	89.00
Terminal IQ	98.29	97.54	97.58

TABLE 2

MEAN GAIN IN IQ IN RELATION TO INTERVAL BETWEEN FIRST AND LAST TESTS

<i>Interval</i>	<i>Boys</i>		<i>Girls</i>		<i>All subjects</i>	
<i>Mos.</i>	<i>N</i>	<i>Mean gain</i>	<i>N</i>	<i>Mean gain</i>	<i>N</i>	<i>Mean gain</i>
4	12	4.58	11	1.64	23	3.17
4+	11	5.91	13	3.15	24	4.42
6+	16	6.12	13	5.46	29	5.84
8+	6	17.50	4	11.50	10	15.10
10+	8	7.88	4	13.00	12	9.59
12+	4	15.25	7	15.14	11	15.19
14+	3	14.33	4	12.75	7	13.42
16+	4	22.00	4	11.25	8	16.62
18+	5	14.60	3	13.67	8	14.25
	<i>N=69</i>	<i>M=9.44</i>	<i>N=63</i>	<i>M=7.49</i>	<i>N=132</i>	<i>M=8.58</i>

TABLE 3
MEAN GAIN IN IQ IN RELATION TO LEVEL OF INITIAL IQ

Initial IQ level	Boys		Girls		All subjects	
	N	Mean gain	N	Mean gain	N	Mean gain
Below 60	1	24.00	—	—	1	24.00
60-69	6	19.82	4	20.25	10	20.00
70-79	7	13.42	10	11.30	17	12.18
80-89	20	12.50	18	12.11	38	12.30
90-99	23	3.78	12	1.75	35	3.09
100-109	8	4.63	16	.56	24	1.92
110-119	3	5.33	3	9.67	6	7.50
120-129	1	24.00	—	—	1	24.00
	N=69	M=9.44	N=63	M=7.49	N=132	M=8.58

TABLE 3 shows the magnitude of IQ change in relation to initial IQ level. It may be noted that those cases showing the greatest increment in IQ tend to be at the extreme levels in initial score. The smallest increments are found among children functioning within the average range at the time of their admission. These data suggest that many of the children who fall initially into the below-average groups are children of normal intelligence who are suffering impairments based on lack of environmental opportunity, or emotional difficulties, or both, and that these cases respond favorably to the institutional environment provided. Those children who per-

form at an average level initially may, in the majority, be those of this same "normal IQ" group, whose functioning is less impaired as a result of environmental inadequacy. The relatively small group of children initially performing at above average level tends to improve significantly. It is suggested that this group is composed of the brighter children whose previous environments provided markedly inadequate intellectual stimulation or markedly severe emotional deprivation.

TABLE 4 shows magnitude of IQ change in relation to age when first examined. Relative age within the two- to seven-year range does not, for the

TABLE 4
MEAN CHANGE IN IQ IN RELATION TO AGE WHEN FIRST TESTED*

Age at initial test	Boys		Girls		All subjects	
	N	Mean gain	N	Mean gain	N	Mean gain
2-0-2-11	10	9.00	9	3.22	19	6.27
3-0-3-11	17	10.18	8	18.25	25	12.75
3-0-4-11	19	11.68	21	7.53	40	9.50
5-0-5-11	12	5.33	14	8.93	26	7.28
6-0-6-11	9	8.78	10	.90	19	4.63
7-0-7-11	2	11.50	1	4.00	3	9.00
	N=69	M=9.44	N=63	M=7.49	N=132	M=8.58

* T value for mean changes in IQ were:
All subjects 8.58 S.D.=11.35 S.E._m= .99 T=5.64 p=<.01
Boys 9.44 S.D.=11.15 S.E._m= .97 T=6.64 p=<.01
Girls 7.49 S.D.=11.58 S.E._m=1.01 T=4.45 p=<0.1

present population, appear to be consistently related to magnitude of improvement in intellectual functioning.

DISCUSSION

The results indicate that, in the present Irvington House institutional environment, the majority of children showed statistically significant increment in level of intellectual functioning. The magnitude of increment seems directly related to duration of stay in the institution, but the optimal interval appears to be approximately one year, as children remaining much longer do not show significantly greater improvement than those remaining up to a year. Also, children remaining less than six months improve relatively little, suggesting that there is at first a settling down period of approximately three or four months, after which the child begins to be able to take advantage of the opportunities his present environment offers which were previously unavailable to him. Most children appear to have recovered from much of the functional deficit within a year after admission, and only relatively few cases show significant further gain within the setting. The children who appear to gain most from the institutional setting are those whose functioning is far below their ability because of environmental and emotional deprivation. In this context it is worth noting that Puerto Rican children, who often come from particularly dilapidated home environments, tend to show unusually large increments in IQ, even though initial testing was conducted in the child's own language, eliminating language factors in testing as a cause for the low initial level.

The findings of the present study suggest that, with respect to intellectual

functioning, the institutional environment of Irvington House tends, for most children, to provide more opportunity and stimulation for growth than did the homes from which these children came. The initial testing was done early in the child's stay (the second to third week), and the beginning scores may be depressed to some extent by the child's upset in a new situation. However, the final testing likewise was undergone when the child was experiencing the impending discharge from Irvington House.

IMPLICATIONS

The findings in relation to length of stay suggest that professional reappraisal of our definition of "temporary" care is in order, and lead us to question the prevalent notion that, if young children must be institutionally placed, the length of stay should be as short as possible. It would appear from the Irvington House experience that the period of from 12 to 16 months after admission would most often constitute the optimal time for transfer to another setting. When children can return to their natural family group, probably they should do so just as soon as their homes are reconstituted. Where foster home placement subsequent to the institutional placement is indicated, however, perhaps we should plan in terms of allowing the child to achieve the maximum benefits of the institution before transferring him, instead of following the policy which is now general, namely, transferring the child as soon as a home is available. Present practice of transferring almost entirely in terms of the availability of foster homes has developed, at least in part, from an untested conviction and emotional commitment to the idea that foster homes are always

better than institutions for young children.

It should be made clear that we are not necessarily advocating institutional rather than foster home placement for children two to seven years old. We would be interested to know what the test experience would be with a similar group of preschool children who were given interim care in foster homes rather than in an institution, or, in an institution with less provision for individual enrichment. Similarly, we would want to know how the children discharged from Irvington House performed several years hence, as compared with children who had had other placement experiences. We do not know whether such comparisons would reinforce the child-care profession in its present commitment to foster homes as the most desirable form of temporary placement, or whether such comparisons might result in a re-evaluation of the institutional role, but our results suggest that some of the old concepts need re-examination.

Finally, our experience at Irvington House leads us to believe that much of the harmful effect of group care of small children reported by previous investigators may have been a function of two factors: the age of the children at placement and the quality of the institutional service offered at that time.

With respect to age, there is no doubt that separation from the natural parents for practically all children under three, for most children between three and five, and for very many children between five and eight creates anxiety, a sense of loss, a sense of guilt and unworthiness and extreme emotional privation, which thereafter handicap the child's future intellectual, school and social adjustment.¹ Bowlby concluded that "when

deprived of maternal care, the child's development is almost always retarded physically, intellectually and socially . . . and that symptoms of physical and mental illnesses may appear." Many of the untoward effects that previous investigators have attributed to the institutional care of small children may very well be due to the separation factor, rather than institutionalization. This may have been particularly true in former times when institutions had an essentially impersonal, ultrahygienic and generally cold atmosphere.

Once the initial trauma of separation occurs, it is by no means certain that institutional care always will be more deleterious than foster home care. Properly conducted institutional care, where warmth in personal relationships, close contact with a particular individual and emphasis on preserving the continuity and identity of the child's life are combined with the attempt to relieve his guilt, may very well be equal to or better than foster home care. This probably is particularly true when the initial foster home proves to be inappropriate, and the child has to be re-placed, or where the other concomitants of separation anxiety are not handled. Further study should seek better differentiation between the young children for whom it may be relatively indifferent whether they are in foster homes or institutional care, those who ideally should have foster care, those for whom an institutional period is necessary as rehabilitation for foster home care and those for whom group care may be advisable if the "perfect" foster home cannot be obtained.

What we need to bear in mind is that "temporary care" actually is often modified, or pre-long-term care (even six

months is a long, long time in the life of a young child). We must face the fact that in the foreseeable future many small children face "temporary" institutional placement. We cannot afford to equate such care with temporary in the sense of surface, or shallow or not making much difference. The quality of the life, the values in the human relationships offered to a child in temporary care, are as important for future adjustment as that which will be offered in his natural family or permanent placement. Our role is not to despair, but to commit our money, our minds and our hearts to making this a constructive period in the child's life. The experience at Irvington House leads us to believe that this is possible.

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