CHAPTER THREE

The Cambridge-Somerville Study

*A Pioneering Longitudinal Experimental Study of Delinquency Prevention**

CLAIMS LINKING FAMILY inadequacies with criminal behavior are far from new. In the seventeenth century, for example, William Gouge (1627) described the duties of family members toward one another by writing that "children well nurtured and by correction kept in filiall awe, will so carry themselves, as their parents may rest somewhat secure" (p. 311). In the nineteenth century, convinced that "all sources of crime … may be traced to one original cause, namely, the neglect of parents as to a proper care of their children," Jevons urged that parents, rather than their children, be punished for their children's delinquency (1834/1970, p. 153). In 1848, the New York City chief of police described the delinquents he encountered as "the offspring of always careless, generally intemperate, and oftentimes immoral and dishonest parents" (Matsell, 1850, p. 14).

By the first quarter of the twentieth century, such observations had become common enough to encourage a movement aimed at preventing crime through use of child guidance clinics. As part of this movement, teams of workers consisting of a psychologist, a psychiatrist, and a social worker joined forces to combat problems believed to be at the root of crime. In 1917, Judge Frederick Cabot invited William Healy, M.D., director of the Juvenile Psychopathic Institute in Chicago, to become head of the Judge Baker Foundation (Mennel, 1973).

Healy (1917) believed that delinquents lacked close emotional ties. Delinquents, he wrote, "never had any one near to them, particularly in family life, who supplied opportunities for sympathetic confidences" (p. 327).

As director of the Judge Baker Foundation (later known as the Judge Baker Guidance Centre), Healy and his codirector, Augusta Bronner, worked closely with Judge Cabot. The Judge Baker Foundation reviewed juvenile court cases, making recommendations to the court regarding placement and treatment.

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Careful case reviews not only served as bases for their recommendations but also enabled Healy and Bronner (1926) to identify common features in the backgrounds of delinquents. Among the discoveries they reported was the fact that less than 10 percent of 2,000 young recidivists had come from "reasonably good conditions for the upbringing of a child" (p. 129). When they compared delinquents with their nondelinquent siblings, they gained additional support for the view that lack of warm interaction in the family was at least partially responsible for crime. Healy and Bronner (1936) discovered that the nondelinquents received more affection. Naturally, recommendations made by the Judge Baker Foundation reflected the perspective of its directors.

Meanwhile, Sheldon Glueck, who had taken a seminar with Richard Clark Cabot (a cousin of Judge Cabot) in 1925, began to study the impact of the juvenile justice system on later criminal careers (Glueck and Glueck, 1945). As part of this assessment, Sheldon and Eleanor T. Glueck retraced delinquents 5 years after official control by the Boston court ended. Disconcertingly, Glueck and Glueck (1934) reported that of the 905 delinquents who could have become recidivists, 798 (88.2%) had done so. Rates of recidivism were only slightly lower among the subset of cases in which the Judge Baker recommendations had been followed. These results produced calls for stronger interventions and greater attention to the broader life setting of delinquents. Healy had suggested attacking the problem of delinquency as it could "be seen developing in school life" (1934, p. 94). This was the climate into which the Cambridge-Somerville Youth Study was born.

In 1934 Dr. Cabot retired from Harvard, where he had served as professor of clinical medicine and of social ethics. His medical work included texts on diagnosis. He had made a mark in the field by showing how to differentiate typhoid fever from malaria, and his etiological study of heart disease was widely recognized as an important medical contribution. Cabot introduced social services to Massachusetts General Hospital and became president of the National Conference on Social Work in 1931. He wrote about social work, the relationship between psychotherapy and religion, and the meaning of right and wrong. His scientific writing and teaching had been broadly critical, and it was reported that the Massachusetts Medical Society considered expelling him for publicly criticizing general practitioners by claiming that most diagnoses were wrong (Deardorff, 1958).

Richard C. Cabot reviewed the Gluecks' study of recidivism for the journal *Survey* and was convinced of the need for more information about the development of criminal behavior. He concluded his review with an expression of admiration that shaped the future of his work: "What piece of social work … is able to declare (with good grounds for its belief) that it has not failed in 88 percent of its endeavors? I honor the Judge Baker Foundation and the Boston Juvenile Court for having welcomed this piece of investigation. They have trusted in the spirit of science though their hopes of success may perish at the hands of that spirit" (1934, p. 40).

Cabot hypothesized that even rebellious youths from ghastly families "may conceivably be steered away from a delinquent career and toward useful citizenship if a devoted individual outside his own family gives him consistent emotional support, friendship, and timely guidance" (Allport, 1951, p. vi). The Cambridge-Somerville Youth Study would test this hypothesis.

Method

The Cambridge-Somerville Youth Study grafted scientific methods onto a social action program. The Youth Study was designed both to learn about the development of delinquent youngsters and to test Cabot's belief about how a child could be steered away from delinquency. Cabot selected as the sites for his study an area of eastern Massachusetts in which poverty was widespread and crimes were common. Within these areas, boys whose ages were less than 12 became potential targets for intervention.

To avoid stigmatizing participants, boys without difficulties as well as those who seemed headed for trouble were included in the program. Between 1935 and 1939 the Youth Study staff used information collected from schools, neighborhoods, courts, physicians, and families to match pairs of boys similar in age, intelligence, physiques, family environments and backgrounds, social environments, and delinquency-prone histories. In the absence of intervention, both boys in a pair would be expected to have similar lives. The selection committee flipped a coin to decide which member of the pair would receive treatment and which would be placed in the control group.[1]

Each boy in the treatment group was assigned to a social worker who tried to build a close personal relationship with the boy and assist both the boy and his family in a variety of ways. Counselors were not allowed to have contact with criminal justice agencies or with boys in the control group, though, naturally, no attempt was made to prevent their receiving assistance from other sources.

Supported by the Ella Lyman Cabot Foundation, the program started with 325 matched pairs of boys. This number was reduced as the United States entered World War II, counselors joined the armed forces, and gas rationing made it more difficult to travel. When a boy was dropped from the treatment program, his "matched mate" was dropped from the control group. In 1942, when 253 boys remained in the treatment program and an equal number remained in the control group, the research staff compared the groups (Powers and Witmer, 1951).

No reliable differences were discovered in comparisons of age, IQ, or whether referral to the Youth Study had been as difficult or not difficult. The two groups had almost identical delinquency prediction scores, as these were assigned by the selection committee summarizing the boys' family histories and home environments. No reliable differences appeared in comparisons regarding the boys' physical health as rated by the doctor after a medical examination, or in mental health, social adjustment, acceptance of authority, or social aggressiveness as reflected by teachers' descriptions of the boys. Nor were reliable differences found in ratings regarding adequacy of the home, disruption of the home, delinquency in the home, adequacy of discipline, standard of living, occupational status of the father, "social status level" of the elementary school attended by the boy (a measure based on the occupational levels of fathers whose children attended the school), or quality of the neighborhood in which the boys resided (Powers and Witmer, 1951).

The average age of the boys at the start of treatment was 10.5. Social workers, psychologists, tutors, a shop instructor, consulting psychiatrists, and medical doctors formed the treatment staff. Boys were seen in their homes, on the streets, and in the headquarters of the project.

To the innovative design in which matched groups provided a basis for random assignment to a treatment or control group, Cabot added the requirement of keeping excellent records. Following any encounter of the staff with a boy in the study or his family, the staff member dictated a report about what had transpired. Throughout the years of the project, counselors reviewed case records at staff meetings. (See Powers and Witmer, 1951, for further details.)

Case workers offered the boys as well as their parents counseling for personal problems; they referred cases to specialists when that seemed advisable. When the program terminated in 1945, boys in the treatment group had been visited, on the average, two times a month for 5½ years. Over half the boys had been tutored in academic subjects; over 100 received medical or psychiatric attention; almost half had been sent to summer camps; and most of the boys had participated with their counselors in such activities as swimming, visits to local athletic competitions, and woodwork in the project's shop. Boys in the treatment group were encouraged to join the YMCA and other community youth programs. The boys and their parents called upon the social workers for help with a variety of problems including illness and unemployment.

Boys assigned to the control group were excluded from activities provided to the treatment group. Members of the control group did receive help, of course. Families, churches, and community organizations provided assistance. The difference between treatment and control groups was not whether boys received help, but rather whether boys received the integrated, friendly guidance provided by the Cambridge-Somerville Youth Study.

Results

The men were born between 1925 and 1934 (mean=1928; *SD*=1.7). The most recent follow-up began when the men were an average of 47 years old. The Youth Study had been designed to prevent antisocial behavior, so measures of criminal behavior were particularly appropriate to its evaluation. Court records had the advantage of objectivity and were independent of self-reporting biases. Although court records yield incomplete records of criminal activities and are likely to reflect cultural, racial, and social class biases, the treatment and control groups would be equally affected by these influences.

In order to evaluate the impact of treatment, names and pseudonyms of the 506 men were checked through the Massachusetts Department of Probation centralized records in 1975–76. If treatment and control group men had migrated differentially from Massachusetts, the evaluations might have produced biased results. To check this possibility, we searched for the men themselves. By the end of 1979, 248 men from the treatment group and 246 men from the control group had been found. Equal proportions in each group, 76 percent, were living in Massachusetts.

As we discovered the men, we expanded record searches to the states where men were known to have lived. To obtain additional objective information about the men, files of the Massachusetts Department of Mental Health, the Division

TABLE 3.1 Effects of Treatment

Outcome	Number
Neither an undesirable outcome	109 pairs
Both an undesirable outcome	42 pairs
Only control group man an undesirable outcome	*39 pairs
Only treatment group man an undesirable outcome	*63 pairs
TOTAL	253

*z=.0226, two-tailed test.

of Alcoholism, state alcoholic clinics, and the Department of Vital Statistics were searched. Records of these agencies yielded information showing which of the men had died and which had been treated for mental illness or alcoholism.

To use a single objective measure for evaluating whether the Cambridge-Somerville Youth Study had affected the lives of its clients, each of the 506 men was classified as having or not having an objectively defined "undesirable" outcome. If and only if a man had been convicted for a crime indexed by the FBI, had died prior to age 35, or had received a medical diagnosis as alcoholic, schizophrenic, or manic-depressive was a man's outcome counted as undesirable. All other men were classified as having no undesirable outcome. Each pair was then placed in one of four categories: (1) neither the man from the treatment group nor the man from the control group had an undesirable outcome; (2) both men had undesirable outcomes; (3) only the man from the control group had an undesirable outcome; or (4) only the man from the treatment group had an undesirable outcome.

Discrepancies within pairs would be interpreted as evidence for effects of the treatment program. Pairs in which only the man from the control group had an undesirable outcome would be considered pairs in which the treatment program had been helpful.

Unfortunately, the objective measure for evaluating outcome indicated that the program had an adverse effect. (See Table 3.1.)

If some of the families resented intervention, failures might be due to their refusals to accept assistance or to that resentment. It therefore seemed reasonable to look at differences in effects of treatment based on whether the treatment group boys had been recipients of the intended program. To make the comparison, families were divided into those who presented problems of cooperation and those who did not. Counselors dictated reports about each of their interactions with the boys or the families, so that most of the case records included several hundred pages. Cases were considered to have shown problems of cooperation if the counselor reported such difficulties or if the case record was exceptionally short (fewer than 25 pages), indicating little interaction. The results, shown in Figure 3.1, indicate that only the cooperative families were affected by the treatment program.

Among the pairs in which the treatment family was uncooperative, the control and treatment boys were equally likely to turn out badly. Among the pairs in which the treatment family was cooperative, however, there were 27 pairs in which the treatment boys turned out better but 52 pairs in which the treatment

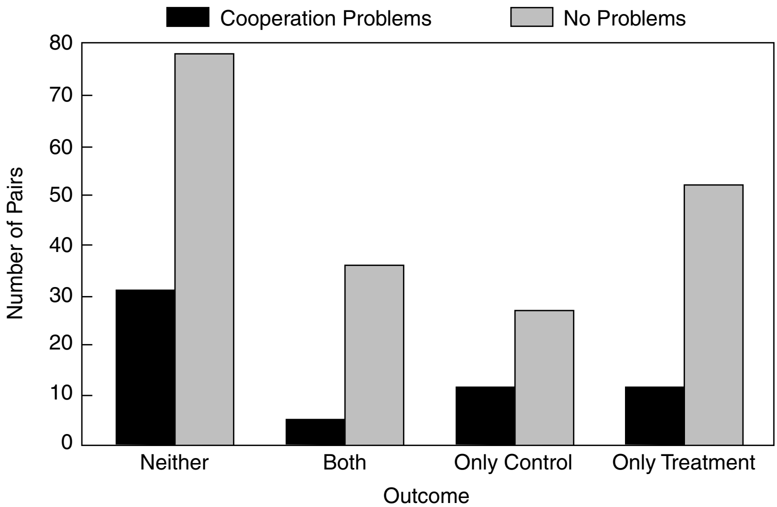

FIGURE 3.1 Case-control comparison: bad outcomes (convicted for Index crime, treated for psychoses or alcoholism, or died before age 35).

boys turned out worse. These findings strongly suggest that the treatment itself had been harmful.

The general impact of treatment appeared to have been damaging. Nevertheless, some subgroups of those who received treatment might have been helped. Beneficial effects might have resulted from starting treatment when the child was particularly young, from providing more frequent help, or from treatment being available over an especially long period of time. None of these possibilities received support. Nor was there evidence to show that some particular variation of treatment had been effective. Moreover, when comparisons were restricted to those with whom a counselor had particularly good rapport or those whom the staff believed it had helped most, the objective evidence failed to show that the program had been beneficial. (See McCord, 1981, 1990a, for details.)

Discussion

Why did the treatment have harmful effects? Part of the reason, it seems to me, has been the compensatory model on which treatment was based. Cabot—and many others—have assumed that an appropriate treatment would undo deficits in backgrounds of people at high risk for developing problems. This can be a critical error. A child rejected by parents may not be best served by someone else who tries to take the role of parent. Such a strategy might result in an exaggerated sense of loss; it might produce expectations for or dependence on assistance.

We know that supervision or "monitoring" is an efficient predictor of socialized behavior. But absence of supervision is likely to have resulted in a set of expectations, adaptations, and (perhaps) skills. So a child who has not been supervised may become *more* antisocial if he is placed under close supervision.

Children who are not good in school may not be best served by tutoring them. Self-identity or peer labeling may make such tutoring reinforce perceptions of inadequacy. Timing could be critical in determining whether a particular intervention would be beneficial or harmful.

In a strange sort of way, we may have come close to assuming that there is a single mold that would be appropriate for all. So we assume that children who are not loved should be given love; children who are doing badly in school should be taught to do better.

Certainly there are alternatives to academic success for satisfactory lives. The same might be said regarding social success.

Despite failure of the treatment program, the records of the Cambridge-Somerville Youth Study provided a rich field for mining information about the homes of 253 boys. These records were coded in 1957, prior to collection of the follow-up data. They therefore were not contaminated by retrospective biases. (See McCord and McCord, 1960, for a complete description of the coding.)

Analyses based on these records have shown that the criminogenic impact of paternal absence depends largely on the nature of the family interaction (McCord, 1990b), that differences between families with and without alcoholic fathers are permeating in terms of variables related to child rearing (McCord, 1988), and that home environments during early adolescence are strong predictors of both juvenile delinquency and of adult criminal behavior (McCord, 1991a).

It has been possible to learn, also, that some patterns of family interaction seem to promote alcoholism (McCord, 1988), while others contribute to competence (McCord, 1991b). It is doubtful that these relationships could have been discovered had not evidence been collected by direct observation and over a relatively long period of time. The opportunity for observation was generated by the treatment provided (Cabot, 1940).

On the one hand, the Cambridge-Somerville Youth Study could be considered a failure because it harmed some of the boys given treatment through its auspices. On the other hand, the study should be considered a success. It was a success because:

1. It showed the importance of using random assignment to treatment and control groups in order to assess the validity of cherished beliefs about helping others. Despite good intentions, iatrogenic effects occurred.
2. It showed that providing supportive friendly guidance was not a sufficient antidote for criminogenic conditions.
3. It showed that careful records collected in the process of providing treatment can yield scientifically valuable information about developmental issues.
4. It demonstrated that intervention can have long-term effects.

On a theoretical level, results of the Cambridge-Somerville Youth Study have two implications. First, they provide grounds for doubting that deficit approaches to reducing crime can be effective. And second, they provide grounds for doubting the adequacy of control theory as an explanation for crime.

Control theory explains crime as the result of failure to develop attachments to family, school, and norms. The Cambridge-Somerville Youth Study succeeded in developing conventional ties—but nevertheless failed to prevent deviant behavior.

Notes

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1. An exception to random assignment was made for eight cases who were matched after the treatment began. In addition, brothers were assigned to that group to which the first of the siblings was randomly assigned. This involved 21 boys in the treatment group and 19 in the control group.

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