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Broken Windows or Window Breakers: The Influence of Physical and Social Disorder on Quality of Life

Allison T. Chappell, Elizabeth Monk-Turner and Brian K. Payne

The relationship between neighborhood disorder and fear of crime is well established. According to Wilson and Kelling’s broken windows theory, physical and social disorder lead to fear and cause citizens to retreat into their homes. This breaks down informal social control mechanisms and may lead to more serious crime. Insofar as fear is related to quality of life, an implication of broken windows theory is that disorder may impact quality of life, but that relationship has not yet been examined in the research literature. The present study seeks to fill a void in the literature by investigating the relationship between neighborhood disorder and quality of life. Results indicate that disorder is related to quality of life. In particular, physical disorder is negatively associated with quality of life, but social disorder loses significance when controlling for physical disorder. Policy implications of the findings and direction for future research are discussed.

Keywords broken windows theory; quality of life; neighborhood disorder; policing; happiness

Introduction

The relationship between neighborhood disorder and fear of crime is well established (Hinkle & Weisburd, 2008). In fact, some research indicates that neighborhood disorder, or incivilities, is a better predictor of fear than serious crime (Kelling, 1981; Skogan & Maxfield, 1981). According to broken windows theory, neighborhood physical and social disorder cause residents to be fearful and retreat from their neighborhoods (Moore & Trojanowicz, 1988; Wilson & Kelling, 1982, p. 36). This breaks down informal social control mechanisms and suggests to residents and outsiders alike that the neighborhood is “uncontrolled and
uncontrollable” (Wilson & Kelling, 1982, p. 33), which ultimately may lead to more serious crime. The idea is that disorder causes fear, and fear leads to activities that cause serious crime.

Broken windows theory has influenced policy, most notably in the policing arena. Policing strategies based on this approach, often termed “quality of life policing,” focus on the elimination of problems, such as panhandling and public drunkenness, vandalism, prostitution, noise, loitering and unruly youths, graffiti and littering, and dilapidated buildings (Kelling, 1987; Kelling & Coles, 1996). It is a variation of community policing that takes a zero tolerance approach to misdemeanors based on the premise that unattended disorder leads to more serious crime. In New York City, “quality of life” policing has been credited with contributing to the unprecedented 1990s crime drop (Bratton & Knobler, 1998; Kelling & Sousa, 2001).

While research in criminology has largely focused on the relationship between disorder, fear, and crime, our goal is to discern whether disorder is inextricably related to quality of life. Indeed, broken windows theory implies that disorder negatively impacts quality of life (Taylor, 2001). According to Kelling (1987) “disorderly behavior powerfully shapes the quality of urban life,” (p. 95) and Moore and Trojanowicz (1988) argued that fear “produces a loss in personal well-being” (p. 3). Other researchers have touched on the fear-quality of life nexus, contending that fear of crime is only one component of a larger construct of quality of life (Garafolo & Laub, 1978; see also Hale, 1988). Furthermore, according to Xu, Fiedler, and Flaming (2005) “Citizen’s fear is a significant predictor of the perceived quality of life, and both are in turn significantly

Allison T. Chappell is an Assistant Professor in the Department of Sociology and Criminal Justice at Old Dominion University in Norfolk, Virginia. She earned her PhD in Sociology from the University of Florida in 2005. Her primary research interests are policing and juvenile justice/delinquency. Her work has appeared in journals such as Crime and Delinquency, Policing: An International Journal of Police Strategies and Management, and the Journal of Contemporary Ethnography. Elizabeth Monk-Turner is Professor of Sociology and Criminal Justice at Old Dominion University. Her most recent work focuses on subjective well being and how this varies by age, in unique samples (yoga practitioners), and between those who exchange money for sex in Thailand and Yunnan, China. How perceptions of personal and community safety shape subjective well being will be a focus of future research. Other research examines work issues (including gender differences in promotional opportunities among correctional officers, how stakeholders perceive key issues in the selection of police chiefs, factors shaping police retention, meditation effects in correctional settings, and how bouncers do their job), factors shaping the decision of male assault survivors to seek counseling, hand washing behavior, and images in readily available internet pornography. Dr. Brian K. Payne is Professor and Chair of the Department of Criminal Justice at Georgia State University. He received his PhD in 1993 in Criminology from Indiana University of Pennsylvania. His research focuses on elder abuse, crime policies, family violence, and community-based sanctions. He is the author of five books including Crime and Elder Abuse: An Integrated Perspective, Crime in the Home Health Care Field, and Family Violence and Criminal Justice and he has published more than 120 scholarly journal articles. His works have been reviewed in outlets such as the New England Journal of Medicine, AgeVenture News, and The Gerontologist. He is a recipient of numerous awards including the Southern Criminal Justice Association’s Outstanding Educator Award and the Indiana University of Pennsylvania’s Department of Criminology Distinguished Scholar Award. Correspondence to: Allison T. Chappell, Department of Sociology and Criminal Justice, Old Dominion University, Norfolk, VA 23529, USA. E-mail: achappel@odu.edu
influenced by disorder” (p. 174). Certainly, fear which causes people to retreat into their homes impacts subjective quality of life. However, this proposition—that disorder affects quality of life—has not yet been empirically examined in the USA.

While past research has found a relationship between disorder and fear, anger, hopelessness, and demoralization (Skogan, 1990), no studies to date have specifically examined the relationship between disorder and subjective quality of life. In fact, few studies have examined the link between perception of crime or victimization and quality of life and happiness (Michalos & Zumbo, 2000). Today, researchers generally understand quality of life (or happiness) as a sense of subjective well-being (SWB) and life satisfaction (Diener, 1984; Diener, Suh, Lucas, & Smith, 1999; Doland & White, 2006; Lu, 1995; Yang, 2008). In the current study, we aim to investigate the relationship between broken windows or neighborhood disorder, and subjective quality of life. In so doing, we will extend broken windows theory and examine whether one key assumption of the theory is empirically supported.

This research is important for policy, research, and theory. Broken windows theory suggests that quality of life can be improved by addressing disorder. But, is disorder actually related to quality of life? Our research has practical and theoretical importance in that this core assumption of broken windows theory—that disorder is predictive of quality of life—remains an empirical question.

Literature Review

Broken Windows Theory

According to Wilson and Kelling’s broken windows theory, disorder (or incivilities) in a neighborhood causes citizens to be fearful and withdraw from neighborhood activities. Disorder is a "signal that no one cares" (Wilson & Kelling, 1982, p. 31), and symbolizes an increased likelihood of serious criminal activity. This, in turn, causes residents to limit their activities (Costa, 1984), decreasing informal social control, and eventually leading to more serious crime. According to Wilson and Kelling (1982), "serious crime flourishes in areas in which disorderly behavior goes unchecked" (p. 34). One of the implications of the theory is that policing efforts that focus on decreasing disorder will lead to increases in informal social control and therefore prevent more serious crime from occurring.

Broken windows theory has led to a number of policing initiatives (Bratton & Knobler, 1998; Kelling & Sousa, 2001; Weisburd & Braga, 2006) that advocate aggressive police tactics aimed to control minor crimes and disorder. These policing practices have been referred to with a variety of terms, such as "zero tolerance policing," "order maintenance policing," and "quality of life policing" (Cordner, 1998). The basic premise of such policing strategies, based on broken windows theory, is that the aggressive enforcement of minor offenses (i.e., disorder) will prevent more serious crime from occurring (Kelling & Sousa, 2001;
Examples of such aggressive enforcement include increasing arrests for disorderly behavior and loitering, increasing code enforcement, and eliminating graffiti (Kelling & Sousa, 2001; Skogan, 1990). Many of these policing efforts explicitly aim to decrease fear and crime as well as improve quality of life (Bennett, 1991). Broken windows theory has notably been credited for contributing to the crime drop in New York City in the 1990s (Bratton & Knobler, 1998; Kelling & Sousa, 2001).

While considerable research has established a relationship between disorder and fear (Covington & Taylor, 1991; Markowitz, Bellair, Liska, & Liu, 2001; Skogan, 1990), other studies have focused on the relationship between disorder and crime. For example, Kelling and Sousa (2001) found that the aggressive enforcement of disorder was associated with decreased violent crime, and Messner et al. (2007) concluded that order maintenance policing reduced gun-related homicides. Other scholars, however, have found that increased enforcement of disorder has had no effect on serious crime (Katz, Webb, & Schaefer, 2001; Novak, Hartman, Holsinger, & Turner, 1999; Sherman, 1990).

While some critics contend that broken windows theory lacks merit and has not been adequately tested (Harcourt, 1998; Sampson & Raudenbush, 1999), others suggest that addressing disorder is a worthwhile pursuit even if it has no direct effect on crime rates. Thacher (2004) argues that order maintenance policing is best judged by its direct impact on public order; that what should be considered is whether attacking public disorder is "intrinsically valuable" (p. 381). He attributes the skepticism by some commentators as a result of "strong causal reasoning" (p. 383) and a reliance on research methods that are unable to adequately capture the reality of order maintenance policing. He suggests that ethnographic techniques may be more appropriate for such an endeavor. Sousa and Kelling (2006) elaborate on this, arguing that "broken windows may have merit beyond the link between disorder and crime" (p. 87). Indeed, policing strategies based on broken windows theory may aim to improve public order with no intent to reduce serious crime. Certainly, research has shown that disorder may cause more fear and concern among the public than serious crime (Kelling, 1981; Skogan & Maxfield, 1981). Thus, even if quality of life policing does not have a direct impact on crime rates, it is possible that it is worthwhile in its own right.

No researchers to date have directly examined the relationship between broken windows theory and quality of life. Outside of criminology, however, a few key studies have looked at the impact of neighborhood disorder on a number of issues that relate to quality of life, such as health and mortality (Chaix, 2009; Cohen et al., 2003; Hill, Ross, & Angel, 2005; Yen, Yelin, Katz, Eisner, & Blanc, 2006), risky behavior (Latkin, Curry, Hua, & Davey, 2007), substance use (Cleveland, Feinberg, & Greenberg, 2010; Wilson, Syme, Boyce, Battistich, & Selvin, 2005), children’s activity levels (Miles, 2008; Molnar, Gortmaker, Bull, & Buka, 2004), depression (Latkin & Curry, 2003; Ross, 2000), drinking (Hill & Angel, 2005), smoking (Miles, 2006), and perceived powerlessness (Geis & Ross, 1998).

Some research has found that the social and physical environment in neighborhoods plays an important role in health and mortality. Research in the health
and medical fields suggests that those who live in neighborhoods plagued with physical and social disorder are less likely to be physically active, which is a risk factor for a number of diseases, including heart disease, diabetes, and cancer (Cohen et al., 2003; Kahn et al., 2002; King et al., 2000; Sallis & Owen, 1996). Research has found that people who perceive high levels of neighborhood disorder are more likely to restrict physical activity (e.g., walking in the neighborhood) and are more likely to have health problems (Wei, Hipwell, Pardini, Beyers, & Loeber, 2005). Furthermore, dilapidated neighborhood conditions likely affect social relationships with those in the neighborhood, and a lack of social relationships has a negative impact on health and quality of life (Cohen et al., 2003; Helliwell & Putnam, 2004; Putnam, 2000). In other words, researchers are recognizing the importance of neighborhood conditions in health and longevity, as people are more likely to spend time outdoors when the neighborhood is pleasant (Cohen et al., 2003).

Christmann and Rogerson (2004) conducted a study in the UK on crime, fear of crime, and quality of life. Interestingly, they found no association between the level of property and violent crime rates and quality of life. However, they did find that neighborhood disorder was a good predictor of quality of life. In fact, it was the third best predictor of quality of life after difficulty with financial debt and poor health. They concluded, "the most direct approach to improving quality of life ... is to address ... physical disorder" (p. i).

Quality of Life

Stemming primarily from the disciplines of psychology and economics, quality of life research has focused on a number of indicators such as work, income and education, health and social relationships, and personal characteristics. For example, a number of studies have examined the impact of income on quality of life and found that income is positively associated with quality of life (Easterlin, 2001; Frey & Stutzer, 2000). However, other researchers challenge this assertion, citing data that the per capita income gap between wealthy and poor countries does not match the gap in quality of life (Layard, 2005; Nettle, 2005). At the individual level, income increases lead to variable outcomes. For the poor, an increase in income has a stronger impact than for the rich. In other words, there seems to be a "baseline;" income affects quality of life to the extent that it helps people meet their basic needs, but after that, the effect is negligible (see Diener, 2009; Diener et al., 1999). Furthermore, it appears that relative, rather than absolute, income is a better determinant of happiness (Ball & Chernova, 2008; Dorn, Fischer, Kirchgassner, & Sousa-Poza, 2007). Similarly, a few studies have examined the role of work in quality of life. This research tends to focus on how hours worked is related to quality of life (Bardasi & Francesconi, 2004; Benz & Frey, 2004; Blanchflower, 2000; Blanchflower & Oswald, 1998, 2005). Little research has examined how employment status, specifically whether or not one works outside of the home, shapes SWB. Education has been
found to have a positive influence on quality of life; notably, this effect is independent of income (Blanchflower & Oswald, 2004; Easterlin, 2001; Fahey & Smyth, 2004).

Extant research has examined the impact of demographic variables, such as age, race, and gender, on quality of life. The findings regarding the relationship between age and quality of life are mixed. Some research has found that quality of life increases as people get older (Charles, Reynolds, & Gatz, 2001; Yang, 2008), while others have found that it decreases (Rodgers, 1982) or stays the same (Costa et al., 1987). Ferrer-i-Carbonell and Gowdy (2007) found that those in their 30s and 40s reported lower life satisfaction than those who were younger or older. Women have been found to have higher quality of life than men (Easterlin, 2001), although one recent study found that while women are happier earlier in life, men are happier later in life (Plagnol & Easterlin, 2008). African Americans have been found to have lower quality of life than whites (Davis, 1984; Hughes & Thomas, 1998).

Health and relationships may also affect quality of life. Many researchers have found a positive relationship between health and quality of life (Bowling, 1996; Seligman, 2002; Shields & Wheatley Price, 2005), although this relationship is complicated by the fact that "the promotion of good health might be indistinguishable from the promotion of a good life" (Michalos, Zumbo, & Hubley, 2000, p. 247; also see Blane, Netuveli, & Montgomery, 2008; Michalos, 2004). Similarly, studies have found a positive relationship between having close family relationships, strong community ties, and friendships and quality of life (Argyle, 2001; Blanchflower & Oswald, 2004; Lelkes, 2006; Lucas & Dyrenforth, 2006; Myers, 2000; Pichler, 2006). Indeed, "social connectedness" and social capital have been linked to higher levels of reported quality of life (Helliwell & Putnam, 2004; Putnam, 2000).

While a few studies have examined the impact of crime on quality of life (Michalos & Zumbo, 2000), limited research has analyzed the role of neighborhood disorder, or broken windows, on quality of life. Commentators have repeatedly implied that a relationship between disorder and quality of life exists, but this relationship has never been directly tested in the USA (for a study in the UK, see Christmann & Rogerson, 2004). In this study, we aim to examine the relationship between disorder and quality of life while controlling for a number of factors that have been found to impact quality of life in prior research.

Our research is important for empirical reasons as well as policy and theory. Empirically, researchers need to be sure that they are accurately framing, understanding, and assessing the consequences of neighborhood disorder. At this point, the idea that disorder impacts quality of life is an empirical assumption. Furthermore, many policies advocate the aggressive enforcement of laws against disorder and low-level criminality in the spirit of improving quality of life. Such efforts may be misplaced if research fails to find a relationship between disorder and quality of life. Finally, our research is theoretically important because it examines broken windows theory in a new context. Some
researchers have argued that the theory has never been adequately tested (Harcourt, 1998) and the present research tests a core assumption of the theory that has lacked empirical examination in the past.

Methods

To assess the impact of disorder on quality of life, a telephone survey of residents living in two large southeastern cities was conducted. The survey was part of a broader quality of life survey focusing on interdisciplinary issues related to quality of life. The survey included several sections including demographic questions and questions about (1) quality of life issues, (2) social networks, (3) neighborhood disorder, (4) health, and (5) interpersonal relationships. The survey took between 15 and 20 minutes to complete.

The telephone surveys were conducted by a research center based at the university where each of the authors worked when the study was conducted. The research center has conducted several different telephone surveys on an annual basis since its inception more than a decade ago. For this survey, the telephone interviewers included students, many of whom had extensive experience conducting telephone interviews. All of the interviewers participated in training that focused specifically on this study.

We purchased a list of 4,795 random telephone numbers from Marketing Systems Group (http://www.m-s-g.com/home.aspx). This total number was selected on the basis of a formula the research center had used in its previous telephone surveys. The goal was to develop a sample of 750 respondents. To estimate the amount of telephone numbers needed, research center staff divided the total number of desired completions by three figures: (1) the estimated working number rate, which was assumed to be 0.75, (2) the estimated cooperation rate, which was assumed to be 0.25, and (3) the eligibility rate, which was assumed to be 0.84. These assumptions were determined by previous telephone surveys conducted by the research center.

Of those 4,795 phone numbers, 1,765 were deemed to be unusable after 10 attempts were made to call the number. This resulted in 3,030 possible phone calls where someone answered the phone. Of the total list of numbers (e.g., 4,795), 746 respondents completed the survey for a response rate of 15.6%. While this rate is arguably low, it is probably more reasonable to calculate the response rate based on the number of phone calls where someone actually answered the phone. Of the 3,030 phone calls, 746 surveys were completed for a cooperation rate of 24.6%. Others have calculated response rate based on answered calls—rather than the total number of telephone numbers—as well (see Payne, Tewksbury, & Mustaine, 2010). Response rates in this range are common in telephone surveys (see McCarty, House, Harman, & Richards, 2006).

1. “A cooperation rate is the proportion of all cases interviewed of all eligible units ever contacted” (American Association for Public Opinion Research, 2009, p. 37).
A majority (69%) of our respondents were females and white (69%). The mean age of our sample was 49. Approximately a third (34%) of the sample reported incomes of $75,000 or higher. Half of respondents worked full time (49%) and 36% had acquired the bachelor’s degree or better. Many (37%) strongly agreed that they socialized with family and friends every week. Half (51%) of respondents said that their health was very good or excellent. Almost a third (31%) reported that 20% fall in income would make them feel very restricted or they would feel it would be difficult to survive (see Table 1).

### Dependent Variable

We created a quality of life index, which is a composite variable of six questions. Respondents were asked about whether or not they were as happy as anyone they knew, accepted things the way they were in their life, felt connected to other people, found much fulfillment in life, led a rich, spiritual life, and enjoyed their daily activities (alpha 0.79). Response options ranged from strongly disagree to strongly agree. The possible range on this variable was 6-24 with lower scores indicating less SWB compared to others (mean 18.95).

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Table 1  Descriptive statistics (N = 746)

<table>
<thead>
<tr>
<th>Dependent variable</th>
<th>M</th>
<th>SD</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality of life</td>
<td>18.95</td>
<td>2.76</td>
<td>6–24</td>
</tr>
</tbody>
</table>

**Independent variables**

<table>
<thead>
<tr>
<th></th>
<th>M</th>
<th>SD</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Race (1 = white)</td>
<td>0.69</td>
<td>0.45</td>
<td>0-1</td>
</tr>
<tr>
<td>Gender (1 = male)</td>
<td>0.31</td>
<td>0.46</td>
<td>0-1</td>
</tr>
<tr>
<td>Age</td>
<td>48.89</td>
<td>16.59</td>
<td>19-94</td>
</tr>
<tr>
<td>Income</td>
<td>8.57</td>
<td>2.81</td>
<td>1-12</td>
</tr>
<tr>
<td>Education (1 = bachelor’s degree)</td>
<td>0.36</td>
<td>0.48</td>
<td>0-1</td>
</tr>
<tr>
<td>Employment (1 = full time)</td>
<td>0.49</td>
<td>0.5</td>
<td>0-1</td>
</tr>
<tr>
<td>Sees family regularly</td>
<td>0.37</td>
<td>0.48</td>
<td>0-1</td>
</tr>
<tr>
<td>Income drop</td>
<td>0.31</td>
<td>0.46</td>
<td>0-1</td>
</tr>
<tr>
<td>Health (1 = very good)</td>
<td>0.51</td>
<td>0.5</td>
<td>0-1</td>
</tr>
<tr>
<td>Resources</td>
<td>14.82</td>
<td>2.43</td>
<td>5-20</td>
</tr>
<tr>
<td>Health (scale)</td>
<td>11.44</td>
<td>4.41</td>
<td>6-30</td>
</tr>
<tr>
<td>Disorganization</td>
<td>8.94</td>
<td>2.69</td>
<td>5-20</td>
</tr>
<tr>
<td>Physical disorganization</td>
<td>5.2</td>
<td>1.64</td>
<td>3-12</td>
</tr>
<tr>
<td>Social disorganization</td>
<td>3.76</td>
<td>1.27</td>
<td>2-8</td>
</tr>
</tbody>
</table>

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2. According to the 2000 US Census, the demographic characteristics of the region were 49.2% male, 62.1% white, 56.8% employed, and 27% with college degree. The median household income was $42,472 (20% make over 75,000), and the median age was 33.5 years (US Bureau of the Census, 2000).
Our measure is similar to those used in other quality of life studies (see Diener, 1984; Michalos et al., 2000; Yang, 2008). According to Yang,

> previous research defines subjective well-being as a state of stable, global judgment of life quality and the degree to which people evaluate the overall quality of their present lives positively ... general happiness is the measure of subjective well-being examined most frequently (2008, p. 204; see also, Diener, 1984).

**Independent Variables**

Race was dichotomized between whites (1) and all others (0). Gender was dichotomized between males (1) and females (0). Age was in years (continuous). Respondents were asked their total household income. Response options included 12 categories and ranged from less than $10,000 to $110,000 and over (continuous). Educational attainment was dichotomized between those with at least a bachelor’s degree (1) and others (0). Employment status was captured as employed full time (1) compared to others (0). Seeing family and friends was a dichotomized variable and coded 1 if the respondent strongly agreed with the statement that they socialized with family and friends every week (1) and (0) otherwise. Respondents who felt they would be very restricted or would find it difficult to survive if their disposable income fell by 20% were coded as (1) compared to those who felt such a drop in income would mean doing without the basics or not being able to do nice things (0). Respondents who rated their health as very good or better (1) were compared to others (0).

Three composite measures were constructed: resources, health, and disorder. Respondents were asked how they felt about their economic resources. Five questions were included in this composite measure with response options ranging from strongly disagree (1) to strongly agree (4); therefore, a low score on this measure would indicate that the respondent felt they did not have sufficient resources for their perceived needs. Respondents were asked if they had sufficient resources for housing, for their transportation, for their medical care, for their future needs, and if they were confident about the future of social security (alpha 0.75).

Questions from the **SF-8 Health Survey** were used to measure items related to health. This survey is designed to quickly assess different indicators of health and well-being (SF-8™ Health Survey, 2008). Respondents were asked six questions to capture health concerns with response options ranging from 1 to 5 (with 1 being no problems); therefore, the possible range on this variable was between 6 and 30 (mean 11.44). A low score would indicate that the respondent reported better health. Respondents were asked if, within the past four weeks, physical health limited activities, they had difficulty with daily work, how much pain they were in, how much energy they had (reverse coded), how much their health limited their social activities, and how much they were bothered by emotional problems (alpha 0.82).
Disorder was captured by five questions that were posed to respondents with response options ranging from strongly disagree (1) to strongly agree (4). The possible range on this variable was 5-20 with a low score indicating neighborhood disorder was not a problem (mean 8.94). Respondents were asked if litter was a major problem in the neighborhood, if there were major signs of vandalism, if a lot of houses around their house had burglar bars on the windows, if unsupervised youth were always in their neighborhood, and if public drinking was a problem in the neighborhood (alpha 0.82).³ In order to capture possible differences between physical and social disorder, the disorder variable was dichotomized between physical disorder (litter, vandalism, and burglar bars) and social disorder (unsupervised youth and public drinking).

Analytic Plan

Utilizing ordinary least-squares (OLS) regression, we explored differences in reported quality of life for a basic model that included demographic variables, an expanded model with composite predictor measures included, and a series of full models with disorder variables added. In this way, we capture how well disorder shapes reported differences in quality of life while controlling for variables that have been shown to impact quality of life in the extant literature.

Results

In our basic model, which included demographic variables of race, gender, and age, none of these variables significantly shaped differences in quality of life (see Table 2). Next, in our expanded model, we added composite measures of resources and health to the model while controlling for income,⁴ education, employment status, how regularly one saw family and friends, health, and how one felt about a fall in income. Income, education, how often one saw family and friends, as well as our composite health and resource variables significantly shaped differences in reported quality of life. Completing at least the bachelor’s degree as well as strongly agreeing to the statement that they regularly saw family and friends was positively associated with quality of life. However, as income went up, respondents reported a decrease in their quality of life. Both of our composite predictor variables, health and resources, were significant in shaping perception of quality of life. Quality of life was positively associated with reporting fewer health problems and the feeling that one had sufficient economic resources for their needs.

³. Note that these items were included in sequential order on the survey, suggesting the respondents would recognize that “unsupervised youth” referred to “problematic” youth rather than kids simply hanging out on the streets.
⁴. One hundred and forty-two respondents did not respond to this question.
Deconstructing an Understanding of Disorder

In our full models, neighborhood disorder variables were included along with other control variables (see Table 3). Again, the initial measure of disorder was a composite variable which included questions that captured both social and physical aspects of neighborhood disorder. Next, this variable was disaggregated and two measures that captured possible differences between social disorder and physical disorder were included in the model. Physical disorder included three of the composite measures (litter, vandalism, houses with burglar bars) while social disorder was measured by how respondents felt about unsupervised youth always being in the neighborhood and public drinking in the neighborhood.

In the full models (see Table 3), results from the expanded model held. Looking at Model 1, we see that those who perceived less (total) disorder in their neighborhoods were significantly more likely than others to report greater quality of life. Looking at a possible difference between physical and social disorder in shaping quality of life, we found that both perceived physical disorder and perceived social disorder were significantly related to quality of life when included in the models separately (see Table 3, Models 2 and 3). Specifically, those who perceived less social and physical disorder in their neighborhoods reported greater quality of life compared to others.

Overall, quality of life differences are shaped by perceived social and physical disorders in neighborhoods; however, does this result hold when these variables are included in both the models? Our composite disorder variable, which

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Table 2  OLS regression models predicting quality of life

<table>
<thead>
<tr>
<th></th>
<th>Basic model (n = 721)</th>
<th>Expanded model (n = 547)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>B (SE)</td>
<td>B (SE)</td>
</tr>
<tr>
<td>Race (1 = white)</td>
<td>0.27 (0.23)</td>
<td>-0.11 (0.24)</td>
</tr>
<tr>
<td>Gender (1 = male)</td>
<td>-0.34 (0.22)</td>
<td>-0.41 (0.23)</td>
</tr>
<tr>
<td>Age</td>
<td>0.00 (0.01)</td>
<td>0.01 (.01)</td>
</tr>
<tr>
<td>Income</td>
<td>-</td>
<td>-0.10 (0.04)*</td>
</tr>
<tr>
<td>Education (1 = bachelor’s degree)</td>
<td>-</td>
<td>0.58 (0.22)**</td>
</tr>
<tr>
<td>Employment (1 = full time)</td>
<td>-</td>
<td>-0.05 (0.23)</td>
</tr>
<tr>
<td>Sees family regularly</td>
<td>-</td>
<td>1.37 (0.22)**</td>
</tr>
<tr>
<td>Income drop</td>
<td>-</td>
<td>-0.01 (0.24)</td>
</tr>
<tr>
<td>Health (1 = very good)</td>
<td>-</td>
<td>0.32 (0.24)</td>
</tr>
<tr>
<td>Resources</td>
<td>-</td>
<td>0.33 (0.05)**</td>
</tr>
<tr>
<td>Health (scale)</td>
<td>-</td>
<td>-0.14 (0.03)**</td>
</tr>
<tr>
<td>Constant</td>
<td>18.84 (0.34)**</td>
<td>15.32 (0.92)**</td>
</tr>
<tr>
<td>R-square</td>
<td>0.001</td>
<td>0.28</td>
</tr>
</tbody>
</table>

*p < 0.05; **p < 0.01; p values computed for two-tailed significance tests.
included both social and physical disorders, was significant in shaping quality of life differences. Likewise, both social and physical disorder variables significantly shaped differences in quality of life. When respondents perceived less disorder, whether that be overall disorder, physical disorder, or social disorder, their perceived quality of life increased. However, when both social and physical disorder variables are included in our model only physical disorder remained significant in shaping differences in quality of life (Table 3, Model 4). It appears that physical disorder in neighborhoods is a key in shaping differences in quality of life. Social disorder (i.e., unsupervised youth and public drinking) is only significant in shaping quality of life when physical aspects of this measure are not included separately in the model. 5 It is worth noting that other researchers have found that measures of social disorder are "narrower in range and quite rare" compared to signs of physical disorder (Gault & Silver, 2008; see also, Sampson & Raudenbush, 1999). This may explain why they are less significant predictors of quality of life than physical disorder.

5. The correlation between physical and social disorder was 0.69 and collinearity diagnostics indicate that multicollinearity is not a problem (i.e., tolerances > 0.40 and variance inflation factors < 2.5 which is well within the acceptable range) (see Allison, 1999).
Discussion

These results provide intriguing insight into the relationship between disorder and quality of life. Analyses of the basic model found that none of our variables were significant in shaping quality of life. In the expanded model, regularly seeing family and friends, having acquired at least a bachelor’s degree, feeling positively about one’s economic resources and reporting fewer health problems were positively related to quality of life. As well, an increase in income was associated with a decrease in perceived quality of life. This variable was significant in both the expanded and full models and the sign and direction of the coefficient were consistent in both models. Extant research indicates that the relationship between income and quality of life is not linear; that is, income seems to affect quality of life to the extent that it helps people meet their basic needs, but after that, the effect is negligible (see generally Diener, 2009; Diener et al., 1999). Thus, the fact that our results indicate that income has a negative impact on quality of life is not that surprising, given the characteristics of our sample (which is wealthier than the general population). Finally, perceiving fewer problems with neighborhood disorder was positively related to quality of life; however, it appears that physical disorder in neighborhoods is what is key (rather than social disorder) in shaping differences in quality of life, all else equal.

This suggests that there is a link between neighborhood disorder (particularly physical disorder), our measure to capture variables tied to broken windows theory, and quality of life. In fact, it seems that—with regard to disorder—physical disorder plays a more significant role than social disorder in producing quality of life. Collectively, these findings point to a number of potential implications for policing, theory, and future research.

One clear implication from these findings is that policy makers and law enforcement executives should not assume that policing practices, such as broken windows policing, can positively influence quality of life by themselves. Certainly, quality of life is produced by a number of variables. When “quality of life” policing occurs, it is possible that addressing social disorder, absent the focus on other types of disorder, will not have a significant influence on quality of life.

Second, and somewhat related, these findings suggest that current policing practices designed to address social disorder may be shortsighted. The inability of policing strategies, such as broken windows policing to address various issues has been noted elsewhere. In fact, according to Sampson and Raudenbush (1999), “the current fascination in policy circles on cleaning up disorder through law enforcement techniques appears simplistic and largely misplaced.” The fact that social disorder is not significant while controlling for physical disorder suggests that law enforcement efforts to address social disorder independent of efforts to address physical disorder are quite possibly “simplistic and largely misplaced.”

Third, law enforcement practices cannot be expected to solve issues of disorder by themselves; instead, law enforcement officials must work with other agencies and units better able to address issues related to disorder. In Oakland, California, the Specialized Multi-Agency Response Team (SMART) program, for
example, involved police officers working with place managers to address crime, while other community officials were given the task of addressing physical disorder (Green, 1995, 1996; Green, Price, & Roehl, 2000; Mazerolle, Kadleck, & Roehl, 1998). Landlords and homeowners were fined if their residence showed continued signs of disorder. As place managers expanded their efforts to work together, drug activity decreased (Mazerolle et al., 1998). Indeed, the police themselves were not able to address physical disorder.

Fourth, in terms of policing implications, quality of life policing (Kelling, 1987) is possibly the inappropriate label given to these law enforcement techniques. This is important because members of the public might have expectations that the policing practices will change their quality of life. From these findings, however, it appears that the dynamics and contextual factors surrounding quality of life cannot be adequately addressed by quality of life policing efforts. In the end, if citizens expect policing practices to improve quality of life (because of the label given to the policing practices), then citizens will likely be disappointed in the results of the policing practices. In effect, the very label of “quality of life” policing may perpetuate negative attitudes about the police, and thereby potentially reduce, rather than improve, quality of life.

These findings have implications for criminological theory. At the broadest level, it seems safe to suggest that the lack of a link between quality of life and social disorder has implications for broken windows theory. In general, broken windows theorists suggest a link between disorder and quality of life. The results reported here support this assumption to a degree. Our results particularly point to the role of physical disorder in producing quality of life. Conversely, the minimal influence of social disorder suggests that the dynamics surrounding the disorder matter in terms of quality of life.

Another theoretical implication has to do with the need to better link broken windows theory and broken windows policing through criminological theory and empirical research. Many of the criticisms of broken windows policing (e.g., that the practice is shortsighted and narrowly defined) seem to stem from the fact that the practices are driven void of empirical theory and research. The current research provides but one set of findings that can be used to help drive broken windows policing. Additional criminological research and theory development is needed to better situate broken windows policing in various communities where it occurs.

A number of limitations warrant that these implications be approached with a degree of caution. Consistent with other studies on disordered communities, our sample was underrepresented in terms of minorities and lower-income residents—groups that have historically been distrustful of social science research (Button, 2008). As well, because we had to limit the number of questions on our survey due to budget constraints, our social disorder measure was somewhat narrow and excluded other possible indicators of disorder that may have led to different results. For example, drug dealing, prostitution, aggressive panhandling, and public drunkenness might be perceived differently by respondents than our indicators of social disorder were perceived.
Future researchers should consider how quality of life policing strategies are specifically tied to quality of life in communities where these strategies occur. Researchers should also focus on how quality of life and broken windows policing strategies are defined by law enforcement officers, policy makers, and citizens. Determining whether the conceptual focus of the practices is consistent with the perceived outcomes of the strategies will help to better understand how these law enforcement practices are received in the community.

In addition, researchers should focus more clearly on the actual goals of these practices, how those goals are defined, and whether the goals are actually met. Finally, researchers should expand their efforts to identify the links between quality of life, various types of disorder, police practices, and the presence of crime in a community. All too often, these relationships are over simplified or assumed. Empirically verifying the relationships will help to determine which response strategies should be most effective.

References


