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Binge-drinking and non-partner aggression are associated with gambling among Veterans with recent substance use in VA outpatient treatment

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Abstract

Background—Gambling is relatively under-assessed in Veterans Affairs (VA) substance use disorder (SUD) treatment settings, yet shared characteristics with substance addiction suggest the importance of understanding how gambling behaviors present in Veterans seeking SUD care.

Method—We evaluated substance use, mental health, and violence-related correlates of past 30-day gambling among 833 veterans (93.4% male, M age 48.3 years, 71.5% Caucasian) seeking treatment in VA outpatient mental health and SUD clinics who completed screening for a randomized controlled trial.

Results—A total of 288 (34.3%) Veterans reported past 30-day gambling. Among those who gambled, 78.8% had cravings/urges to gamble, whereas between 20%–27% of gamblers reported perceived relationship, legal, and daily life problems related to gambling, as well as difficulty controlling gambling. A logistic regression analysis revealed that age, recent binge-drinking, and non-partner physical aggression were associated with recent gambling.

Conclusions—Gambling was associated with binge-drinking and non-partner physical aggression, supporting potential shared characteristics among these behaviors such as impulsivity and risk-taking, which may complicate SUD treatment engagement and effectiveness. Findings support the need for screening for gambling in the VA, and to adapt treatments to include gambling as a potential behavioral target or relapse trigger, particularly among heavy drinking patients.

Keywords

gambling; alcohol; treatment; Veterans; substance use problems

1. Introduction

Veterans receiving care at Veteran's Affairs (VA) medical centers typically have high rates of co-occurring psychiatric (e.g., depression, anxiety, Post-Traumatic Stress Disorder [PTSD]) and Substance Use Disorder (SUD) diagnoses (Bonn-Miller, Bucossi, & Trafton, 2012; Seal et al., 2011; Stecker et al., 2010; Wisco et al., 2016). Additionally, evidence suggests that Veterans with co-occurring conditions are more likely to drop out of treatment before completion (Oliva et al., 2013). Psychiatric diagnosis, and SUD diagnoses and substance use-related problems, are associated with a greater risk of homelessness, disability, co-occurring biomedical complications, and greater service utilization among Veterans (Bowe & Rosenheck, 2015). Therefore, it is important for VA providers, or civilian providers working with Veterans in non-VA clinics, to identify potential screening and intervention needs as well as factors that might interfere with treatment engagement and retention in this population.

One such factor is the co-occurrence of addictive and/or impulsive behaviors that might impact the course of treatment, therefore contributing to continued SUD/psychiatric problems or potential relapse. For example, problem and pathological gambling share many characteristics with substance addiction (e.g., craving/appetitive urge, repeated engagement despite adverse consequences, reduced self-control; Wareham & Potenza, 2010), and Veterans appear to have a greater prevalence of gambling and gambling-related consequences compared to the general population (Westermeyer et al., 2013). Additionally, such problems appear to be under-assessed and under-treated in VA treatment settings (Edens & Rosenheck, 2012; Drebing et al., 2001), and thus represent an important treatment consideration among this high-risk population.

Although evidence suggests that recreational gambling can be associated with better health functioning (Desai et al., 2004), and have a positive impact on life satisfaction (Humphreys, Nyman, & Ruseski, 2016), the majority of evidence suggests that recreational and pathological/problem gambling frequently co-occur with other high-risk problems underscored by impulsivity (Potenza, Maciejewski, & Mazure, 2006; Rash, Weinstock, & Van Patten, 2016). For example, among Veterans, gambling has been associated with suicidal ideation and attempts (Kausch, 2003a, 2003b; Kausch, 2004), substance use and SUDs (e.g., alcohol use and use disorders; Desai et al., 2004; Edens & Rosenheck, 2012; Kausch, 2003a; Potenza, Maciejewski, & Mazure, 2006; Rash, Weinstock, & Van Patten, 2016; Westermeyer et al., 2005; Westermeyer et al., 2008), and with psychiatric disorders (e.g., depression, anxiety; Edens & Rosenheck, 2012; Westermeyer et al., 2005; Westermeyer et al., 2008). Similarly, violence and aggression (e.g., partner and non-partner violence; aggressive behavior; family violence) have been associated with both pathological and problem gambling among civilians (Parke & Griffiths, 2004; Korman et al., 2008; Goldstein et al., 2009; Adachi & Willoughby, 2013; Suomi et al., 2013; Roberts et al., 2016;

Dowling et al., 2014; Dowling et al., 2016), and data from a nationally representative sample in the United States (US) showed that the odds of violent behavior are significantly greater among individuals with gambling problems (Pulay et al., 2008). Further evaluation contextualizing the co-occurrence of violence with gambling and in SUD samples, particularly among Veterans, could inform clinical efforts with such patients.

Given the variety of negative associations of gambling, and the possibility that any of these co-occurring problems could interfere with treatment retention and success, it is crucial to understand the potential gambling-related concerns among treatment-seeking Veterans with SUD problems. Not only could this information help inform treatment planning, but it also has the potential to reduce the risk of negative outcomes associated with multiple high-risk behaviors in a population with complex biomedical and psychiatric needs. The present study begins to address this issue by evaluating the prevalence and correlates of gambling among Veterans with recent substance use seeking treatment at a VA outpatient program. Based on prior research (Pulay et al., 2008; Goldstein et al., 2009; Korman et al., 2008; Adachi & Willoughby, 2013; Edens & Rosenheck, 2012; Westermeyer et al., 2005; Westermeyer et al., 2008; Kausch, 2003a, 2003b; Kausch, 2004), we expected significant differences between Veterans with and those without recent gambling on the following variables: alcohol consumption, partner and non-partner physical aggression, psychiatric symptoms (e.g., depression and anxiety), and suicidal ideation. Although PTSD is quite prevalent in Veteran populations (Wisco et al., 2016), prior research has shown that gambling is not consistently associated with PTSD symptoms/diagnosis among Veterans (e.g., Biddle, Hawthorne, Forbes, & Coman, 2005; Edens & Rosenheck, 2012; Westermeyer et al., 2008; Westermeyer et al., 2005). Therefore, we included PTSD symptoms as a relevant covariate in this high-risk population, but did not have a specific hypothesis given this inconsistency in the literature.

2. Method

2.1 Recruitment & Procedure

The secondary data included in this report were collected as part of screening for a randomized controlled trial (RCT) of a substance use and violence prevention intervention. Details regarding study procedures have been described elsewhere (see Davis et al., 2016; Anderson et al., in press). To be eligible for the screening, participants had to have recent substance use, be in outpatient treatment (SUD or Mental Health), provide written consent, read/speak English, and must not have active psychosis, suicidal ideation, cognitive problems, a legal guardian, be in another intervention study, or live outside the catchment area. Participants earned \$10 in gift cards for the screening. Although 839 individuals completed screening for the trial, there was missing data on our primary dependent measure for 6 people; thus, the current analytic sample comprised 833 individuals. The local VA's institutional review board approved all procedures.

2.2 Measures

2.2.1. Gambling Characteristics—Past month gambling and related outcomes were assessed using items we created for this study parallel to items on the Alcohol, Smoking and

Substance Involvement Screening Test (ASSIST; WHO ASSIST Working Group, 2002). Participants first reported on past-month frequency of gambling on a scale from “0 = Never” to “5 = more than once a day.” Those responding more than “Never” also completed past-month items assessing: a) strong desire to gamble; b) health, social, family/relationship, legal, or financial problems as a direct result of gambling; c) failure to fulfill normal expectations because of gambling; d) concern expressed by friend or relative; and e) failed attempts to cut back or quit gambling. All gambling-related items were dichotomized for ease of interpretation and to resolve problems related to residual diagnostics in the model. For the purposes of the present study, we were interested in measuring gambling and potential related problems proximal to treatment entry (i.e., past 30 days). Because most gambling screening measures focus on lifetime or past year diagnostic criteria for pathological gambling, we created a broader set of items to assess potential consequences and our measure had significant overlap with constructs included in other screening instruments (Wickwire et al, 2008; Lesieur & Blume, 1987).

2.2.2. Posttraumatic Stress Disorder Checklist – Civilian (PCL-C)—This questionnaire is comprised of 17 items that assess PTSD symptoms (e.g., “Avoid activities or situations because they remind you of a stressful experience from the past,” “Repeated, disturbing memories, thoughts, or images of a stressful experience from the past”; Gerrity, Corson, & Dobscha, 2007; Weathers, 1996) based on the criteria described in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV-TR, American Psychiatric Association, 2000). Each participant was asked to self-report how much these symptoms had bothered him or her during 30 days prior to screening on a scale from “1 = Not at all” to “5 = Extremely.” Based on recommendations from the National Center for PTSD (2014), we chose to use the conservative cutoff score of 50 to indicate significant symptoms of PTSD in the present study. Because of an error in the screening survey, item 17 (i.e., “Feeling jumpy or easily startled”) was not assessed. We adjusted scores using a mean substitution method in order to account for this error. Cronbach’s alpha in our sample was .95.

2.2.3. Patient Health Questionnaire – 9 (PHQ-9)—This questionnaire is comprised of nine items assessing symptoms of major depression (e.g., “Feeling down, depressed or hopeless,” “Little interest or pleasure in doing things”). Each participant was asked to rate how often he or she experienced these symptoms during the previous two weeks on a scale from “0 = Not at all” to “3 = Nearly every day.” A score of 10 or greater on the PHQ-9 is indicative of clinically significant depression symptoms (Kroenke, Spitzer, & Williams, 2001). Cronbach’s alpha in our sample was .90. In addition to evaluating overall depression symptoms, we used item 9 (i.e., “Thoughts that you would be better off dead or of hurting yourself in some way”), in order to evaluate suicidal ideation as an independent variable.

2.2.4. Generalized Anxiety Disorder – 7 (GAD-7)—This questionnaire is comprised of seven items that assess anxiety symptoms (e.g., “Not being able to stop or control worrying,” “Feeling nervous, anxious, or on edge”) consistent with diagnostic criteria set forth in the DSM-IV (Spitzer, Kroenke, Williams, & Lowe, 2006). Each participant was asked to rate the extent to which these symptoms had bothered him or her during the

previous two weeks on a scale from “0 = Not at all” to “3 = Nearly every day.” The GAD-7 yields a severity score and a score of 10 or higher is considered clinically significant anxiety (Spitzer, Kroenke, Williams, & Lowe, 2006). The Cronbach’s alpha in the present sample was .93.

2.2.5. Substance Use—We used items adapted from the Substance Abuse Outcomes Module (SAOM) in order to assess for recent substance use (Smith et al., 1996). Specifically, each participant was asked to report the number of days (0–30) during the month prior to screening that they used a variety of licit and illicit substances. For the present study, we focused on the most frequently used substances in our sample, alcohol (past month days of use, past month days of binge-drinking, and average number of drinks per drinking day) and marijuana.

2.2.6. Violence Involvement—Partner violence perpetration was assessed using the physical assault subscale from the Revised Conflict Tactics Scale (CTS2; Straus et al., 1996). As done in prior research (Chermack et al., 2009; Murray et al., 2008), to assess non-partner violence we used parallel versions of the partner-directed items to also assess violence directed at non-partners (e.g., “I kicked someone other than my partner”). Items were rated on a frequency scale ranging from “0 = Never” to “6 = 20+ times” over the past year. Participants were instructed to avoid reporting on combat-related violence when answering these items. We computed frequency variables for the two subscales using the midpoint anchor for each response option. Cronbach’s alpha was .91 for partner violence and .91 for non-partner violence.

2.2.7. Military Service History—We selected four items from the original 49-item PTSD Status Form (National Center for PTSD, 1990) to evaluate each participant’s military service era (i.e., Vietnam, Post-Vietnam, Persian Gulf, Operation Enduring Freedom/Iraqi Freedom/New Dawn; not mutually exclusive).

2.2.8. Demographic Characteristics—These single item questions were used to collect information regarding participants’ age, gender, ethnicity, employment status, relationship status, and current legal status.

2.3 Statistical Analyses

First, we categorized participants into two groups based on whether they reported gambling in the 30 days prior to screening. We then conducted descriptive analyses comparing the two groups on demographic variables, gambling experiences, military service history, violence/aggression, substance use, and mental health measures (depression, anxiety, and PTSD). For comparisons involving binary variables, we conducted chi-square tests and for continuous variables we used t-tests; sensitivity analyses replacing these with non-parametric tests (e.g. the Kruskal-Wallis test) showed no substantive differences. Finally, in addition to controlling for demographics (i.e., age, gender, race, marital status, and employment status), all significant bivariate associations were entered into a logistic regression analysis (with the exception that we chose only one alcohol variable to include, due to inter-correlation) to calculate adjusted effects of each covariate’s association with gambling. Due to the large

scale of the aggression scale measurement, standardized odds ratios are reported. Similarly, for substance-use days, odds ratios are expressed as the increased risk associated with a 10-day increase in substance use days; this was chosen over standardization to preserve ease of interpretation (i.e., excess risk associated per substance use day) while also placing the odds ratio on a larger scale.

3. Results

3.1 Participant Characteristics

The sample ($n=833$) was primarily comprised of middle-aged Caucasian men from the larger study (Davis et al., 2016, Buchholz et al., 2016) who completed the gambling item (i.e., 6 participants had missing data and thus were excluded). A total of 288 (35%) participants gambled at least once during the 30 days prior to assessment. Of these, 65 (23%) had gambled several days a week in the past 30 days. In the past month, of the 288 reporting recent gambling, 79% ($n=227$) reported they experienced cravings/urges to gamble, 27% ($n=79$) reported health, social, relationship, legal, or financial problems due to gambling, 21% ($n=60$) indicated failure to meet responsibilities due to gambling, 20% ($n=59$) had others express concern for their gambling, and 24% ($n=70$) reported failure to control their gambling. See Table 1 for demographic, mental health, substance use, and violence-related characteristics.

3.2 Associations with recent gambling

As Table 1 shows, bivariate analyses reveal that, compared to those without recent gambling, participants who reported recent gambling had significantly more days of recent alcohol use, $t(824) = 4.44, p < .001, d = 0.32$, had higher mean number of standard drinks per day, $t(823) = 2.87, p = .004, d = 0.21$, and had higher number of binge-drinking days, $t(823) = 4.18, p < .001, d = 0.31$. Additionally, recent gamblers had more frequent violence with non-partners, $t(831) = 3.12, p = .008, d = 0.23$; but partner violence did not differ across groups. Similar results, shown in Table 2, were found in a binary logistic regression. Older age, binge-drinking, and non-partner aggression all were related to higher odds of gambling. No other relations were significant.

4. Discussion

The results from the present study supported our hypotheses regarding the associations between recent gambling and alcohol use (i.e., quantity of consumption, binge-drinking), and aggression (non-partner physical aggression), among a sample of Veterans with recent substance use in VA outpatient treatment. Although the findings related to alcohol consumption are consistent with prior research with those diagnosed with pathological gambling (Goldstein et al., 2009; Kausch, 2003a; 2003b), and civilians who endorse recreational gambling (Potenza, Maciejewski, & Mazure, 2006; Rash, Weinstock, & Van Patten, 2016), our findings extend this research to a population of Veterans who acknowledged, at minimum, recent gambling but may not necessarily meet criteria for a gambling disorder. Additionally, this study was the first to find, in a Veteran sample, that

non-partner physical aggression is associated with recent gambling, suggesting an area for assessment, intervention, and further research.

Other findings from this study were inconsistent with the literature. Based on prior research (Dowling et al., 2014; Dowling et al., 2016; Suomi et al., 2013; Korman et al., 2008; Folino & Abait, 2009; Roberts et al., 2016) we expected gambling would be associated with intimate partner aggression. However, our sample was comprised of mostly single US military Veterans, and the research related to gambling and partner aggression has focused solely on samples comprised of civilians, and generally has not included measurements of non-partner aggression despite the high co-occurrence of violence across partner and non-partner relationships, particularly among SUD treatment populations (Chermack, Fuller, & Blow, 2000). Although the target of one's aggression may differ depending on norms within a specific population (i.e., Veteran vs. non-Veteran), it is also possible that other variables, such as social desirability or the age of our sample (which is somewhat older than other treatment samples examining violence), could result in lower rates of intimate partner aggression and thus could have also attenuated responses in our study. It could also be that social contexts facilitative of gambling (e.g., casinos, racetracks, bars) increase exposure to risky situations where non-partner violence is more likely to occur compared to intimate partner violence. Future research regarding gambling and aggression should consider more comprehensive assessment of violence across relationship types.

Contrary to our expectations, there were also no relations between recent gambling and several indicators of mental health problems (i.e., anxiety, depression, suicidal ideation) among our sample of Veterans. For example, based on prior research (Kausch, 2004) we expected gambling to be associated with suicidal ideation. However, we used one item from the PHQ-9 (i.e., item nine) as the marker for suicidal ideation, and it is possible that this item may be better suited as a marker of general self-harm/distress as opposed to thoughts about suicide. Additionally, the lack of association in this sample may be related to fact that this was not a gambling treatment-seeking sample, and thus was likely comprised of Veterans with less severe patterns of gambling compared to prior findings (Kausch, 2004). Similarly, other studies (Edens & Rosenheck, 2012; Westermeyer et al., 2005) found that gambling was related to anxiety and depression among Veterans with a diagnosis of pathological gambling and it is quite likely that higher rates of depression and anxiety are associated only with those Veterans with severe gambling problems. Moreover, to the best of our knowledge, no study has evaluated mental health related variables among Veterans with gambling problems using structured diagnostic interviews. Given the high rates of comorbidity in this population (and in our sample), such structured diagnostic interviewing may be an important avenue for future research.

There are several limitations to consider when interpreting the findings from this study. For example, our sample was comprised primarily of male Veterans from a single setting and more research is needed to determine whether our findings generalize to others. Additionally, our study relied on secondary data and a cross-sectional design and so it is difficult to ascertain the temporal direction of effects and no causal attributions can be made. Moreover, our screening survey relied on self-report, and biases related to social desirability and retrospective recall could have influenced our findings.

Although our items assessing potential gambling problems incorporated constructs relevant to other addictive behaviors (e.g., craving, failed attempts to cut down, impaired relationships), our study also lacked a previously validated measure of problems unique to gambling, thus we only chose to present these items descriptively. As such, we could not ascertain whether gambling was only recreational or whether the Veterans in this sample would have met criteria for a gambling disorder, yet several did endorse recent concerns related to gambling that could warrant further assessment. Nevertheless, our single-item dependent variable (i.e., past-month gambling, dichotomized for analyses) was meant only to capture recent gambling, and was not designed to comprise a validated scale of problem/pathological gambling, therefore this limitation is somewhat tempered. Future research should attempt to ascertain the severity of gambling consequences consistent with DSM criteria among Veterans with substance use problems to determine whether there are differences in the associations of recreational versus pathological gambling in this population and how such differences may relate to treatment engagement and contribute to potential relapse.

4.1 Conclusion

Our findings suggest that about one-third of Veterans with recent substance use in VA outpatient treatment have recently gambled, and many of them reported craving for gambling and a variety of potential consequences from gambling. These Veterans were also more likely to engage in binge-drinking and non-partner physical aggression compared to those Veterans with substance use problems who do not gamble. These associations support the hypothesis that there could be overlapping pathways for impulsivity and risk-taking among these behaviors for some Veterans, which could contribute to difficulties with SUD treatment engagement and retention if not addressed simultaneously. The degree to which one learns to manage such impulses in all relevant contexts could have beneficial outcomes (e.g., decrease number of lapses/relapses, decreased legal involvement). Therefore, it is critical for future research to examine whether addressing the co-occurring concerns associated with gambling and substance use increases treatment engagement or retention. For example, rigorous longitudinal studies are needed to understand the inter-relationships among binge-drinking, non-partner violence and gambling over time. Such research could provide information regarding potential causal influences, and can help inform development and refinement of treatment intervention approaches.

Our findings also suggest increasing screening and referral efforts for gambling problems in VA outpatient mental health and SUD treatment, particularly because a large number of those who had gambled reported potential consequences and because gambling may be a more socially acceptable behavior to disclose and is a potential marker for more severe problems (e.g., violence involvement). Given the demands on VA clinicians to screen for and intervene on a number of problems, it may be that utilizing a single item to query past 30-day gambling would be useful in determining whether further assessment is needed. Not only would consistent screening help identify those Veterans most likely to benefit from intervention, but understanding the scope of these problems at the national level may help target prevention efforts. Furthermore, once identified it may be useful to adapt treatments to include gambling as a potential target or relapse trigger, particularly among heavy drinking

patients. For example, CBT interventions targeting such issues could involve augmenting SUD treatment with integrated (addressing binge-drinking, non-partner violence, gambling, and their inter-relationships) or simultaneous (separate but co-occurring interventions targeting each behavior) treatment approaches.

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Table 1

Substance use, violence/aggression, psychiatric, and demographic characteristics of the overall sample and of those with and those without a report of recent gambling.

	Overall (<i>n</i> = 833) ^a	Recent Gambling (<i>n</i> = 288) ^b	No Recent Gambling (<i>n</i> = 545) ^c	<i>p</i> -Value ^d
	<i>n</i> (%) or <i>M</i> (SD)	<i>n</i> (%) or <i>M</i> (SD)	<i>n</i> (%) or <i>M</i> (SD)	
<i>Sociodemographic characteristics</i>				
Age	48.2 (13.3)	49.5 (13.2)	47.6 (13.3)	NS
Male	778 (93%)	275 (96%)	503 (92%)	NS
Caucasian ^e	596 (72%)	200 (70%)	396 (73%)	NS
Employed	201 (24%)	65 (23%)	136 (25%)	NS
Married/live together	254 (30%)	89 (31%)	165 (30%)	NS
On probation/parole	187 (22%)	65 (23%)	122 (22%)	NS
<i>Military History</i>				
OEF/OIF/OND ^f Era Veteran	250 (30%)	82 (28%)	168 (31%)	NS
<i>Past 30-day substance use</i>				
Average number of recent days drinking alcohol	11.5 (11.9)	14.0 (12.1)	10.2 (11.7)	<0.001
Average number of standard drinks per day	6.1 (7.2)	7.1 (6.8)	5.6 (7.3)	0.004
Average number of binge days (5+ drinks/day)	8.9 (11.3)	11.2 (11.8)	7.8 (10.8)	<0.001
Average number of recent days using marijuana	4.4 (9.3)	5.1 (9.9)	4.1 (8.9)	NS
Non-prescribed sedative days	0.7 (3.7)	0.6 (3.4)	0.7 (3.9)	NS
Prescribed sedative days	2.6 (7.6)	2.4 (7.3)	2.7 (7.7)	NS
Cocaine days	1.8 (5.7)	1.9 (5.8)	1.6 (5.5)	NS
Heroin days	1.2 (5.0)	1.2 (5.0)	1.2 (5.1)	NS
Prescribed opioid days	3.3 (8.3)	3.1 (8.0)	3.4 (8.5)	NS
Non-prescribed opioid days	2.0 (6.4)	2.3 (6.7)	1.7 (6.1)	NS
Tobacco use days	18.3 (14.0)	19.5 (13.8)	17.6 (14.1)	NS
<i>Past-year aggression</i>				
Partner physical aggression	2.7 (12.7)	2.6 (10.1)	2.7 (13.8)	NS
Non-partner physical aggression	4.4 (13.7)	6.4 (18.0)	3.3 (10.7)	0.008
<i>Psychiatric Variables</i>				
PTSD Symptom Checklist (cutoff of 50)	331 (40%)	127 (44%)	204 (37%)	NS
Patient Health Questionnaire - 9 (cutoff of 10)	463 (56%)	158 (55%)	305 (56%)	NS
Generalized Anxiety Disorder - 7 (cutoff of 10)	399 (48%)	140 (49%)	259 (48%)	NS
Recent self-harm ideation (PHQ Question #9)	208 (25.0%)	70 (24.3%)	138 (25.3%)	NS

^aNumber of participants varied (*n* ranged from 827–833) due to missing data.

^bNumber of participants varied (*n* ranged from 277–288) due to missing data.

^cNumber of participants varied (*n* ranged from 537–545) due to missing data.

^dChi-square for tests of proportions and a *t*-test for means

^eDichotomized into Caucasian vs. Other due to the large number of Caucasians in the sample

^f OEF = Operation Enduring Freedom; OIF = Operation Iraqi Freedom; OND = Operation New Dawn

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Table 2

Odds of recent gambling (n=817)

	O.R. (95% CI)
Age	1.02 (1.00, 1.03) *
Male	0.65 (0.33, 1.21)
Caucasian	0.87 (0.62, 1.23)
Married/live together	1.07 (0.77, 1.48)
Employed	1.00 (0.69, 1.44)
Average number of binge days (5+ drinks/day)	1.27 (1.11, 1.44) ***
Average number of recent days using Marijuana	1.12 (0.96, 1.31)
Average number of recent days using Tobacco	1.10 (0.99, 1.23)
Non-partner physical aggression	1.22 (1.05, 1.44) *

*
 $p < .05$,***
 $p < .001$