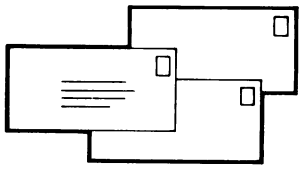

Letters to the Editor

Letters to the Editor are welcomed and will be published, if found suitable, as space permits. Submission of a Letter to the Editor constitutes permission for its publication in the Journal. Letters should not duplicate similar material being submitted or published elsewhere. Letters referring to a recent Journal article should be received within three months of the article's publication. The editors reserve the right to edit and abridge letters, to publish replies, and to solicit responses from authors and others.

Letters should be submitted in duplicate, double-spaced (including references), and should not exceed 400 words.

The Female Condom

Changes in behavior and barrier methods of contraception are at present the only ways of slowing the sexual transmission of the human immunodeficiency virus (HIV). The female condom represents a new and potentially important addition to the existing choices. The preliminary study by Bounds, *et al,*[1] of 24 married or cohabiting couples found 63 percent of the men and 70 percent of the women reported the effect of sexual pleasure to be no different or better than with the male condom. Because the female condom is made of polyurethane, a material more durable than rubber, and covers a larger surface area, it may provide better protection than a standard latex condom. In addition, early reports on the US-made WPC-33 female condom (similar to the one reported by Bounds, *et al,*) suggest that the risk of female exposure to seminal fluid is less when WPC-33 is used as compared to a male condom.[2]

We tested the acceptability of the US-made WPC-33 female condom among 20 high-risk female sex workers[3] in Khon Kaen, Thailand, trained by nurses to use the female condom; we supplied 20 unlubricated devices for each woman, as well as a supply of lubricant and their regular supply of male condoms. The participants were instructed about the risk of AIDS (acquired immunodeficiency syndrome) and advised that they could use the female condom as an alternative method of protection to the male condom. The decision of which device to use, if any, was left to the participant.

Two weeks later, participants reported using the female condom alone in a total of 78 (32 percent) of 247 episodes of vaginal intercourse, eight episodes of which were in conjunction with the male condom. The male condom was used in 90 (35 percent) of the episodes and no condom in 87 (34 percent) episodes. Two-thirds of the volunteers reported no aversion to the female condom while one-third disliked it. Mechanically, the female condom performed well. No rips or tears were reported during intercourse, and no woman reported severe pain. The most common objection to the 17 cm device for these Thai women was that it was too big. Also, the need to lubricate the condoms made their use messy and inconvenient. Nineteen participants said the female condom was less convenient to use than the male condom, and six said it was less comfortable. Most of these problems can be overcome by shortening and pre-lubricating the condoms. One other objection was difficult inserting (15 percent), a problem which may have been due to lack of experience with inserting the condoms.

While the participants' own general assessment of the condom was fairly positive, most discontinued using the device because of male partner objection. Ten respondents reported that all partners with whom they used the female condoms objected to their use; eight said reactions were mixed; and two said all partners with whom they tried them reacted positively. Eighteen of 20 participants said they would advise other sex workers to try these female condoms.

We are now preparing to repeat this study at the same site, using 15 cm pre-lubricated female condoms. Revised instructions will be provided by the manufacturer, and each participant will be required to practice inserting at least two of the devices before initiating the study.

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3. Sakondhavat C: Consumer preference study of a female condom in a sexually active population at risk of contracting AIDS: Final Report. Khon Kaen, Thailand, July 1989.

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Editor's Note: See also related commentary by Z. Stein, p 460 this issue.

Personality Traits and Addictive Disease

It is not at all surprising that Yates, *et al,*[1] found that cocaine patients exhibited more eccentric, flamboyant, and anxious personality traits on the Personality Diagnostic Questionnaire (PDQ) than did either alcoholic patients or community controls. However, a slight reworking of their data reveals that alcoholic subjects averaged 1.87 (88/47) traits per subject for all PDQ clusters, almost as many as the mean of 2.17 (128/59) per cocaine abuser (many if not most of whom would almost certainly have met the diagnostic criteria for cocaine dependence had DSM-III-R been used rather than DSM-III). Community controls averaged only .62 (43/69) traits per subject. Nor is it surprising that cocaine subjects scored significantly higher on the narcissism trait. Alcohol abuse or dependent and cocaine abuse or dependent subjects have all been neurophysiologically "hot-wired" by their drug of choice; they are all "emotionally augmented,"[2,3] as the PDQ predictably revealed.

But to conclude that narcissism or any other "personality factors appear to be worthy of further study as risk factors for the initiation and maintenance of cocaine or other drug abuse" or, worse, that "identification of high-risk personalities, and better understanding of the natural history of personality development, might allow for intensive preventive measures among