

fenses arising in response or anticipation, indeed of what had perhaps been, until then, outside conscious awareness. In this way, I believe—recognition, articulated by another and one's self—therapeutic action in a dynamic psychotherapy takes hold.

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#### Drs. Gabbard and Horowitz Reply

TO THE EDITOR: We thank Dr. Schwaber for her thoughtful letter. We agree that locating the patient's perspective is critically important in the psychotherapy of borderline personality disorder. Indeed, finding that perspective and validating its legitimacy is a cornerstone of both mentalization-based therapy and dialectical behavior therapy. In our article, we noted that transference interpretation of borderline personality disorder only works if the road has been paved with empathic validation of the patient's point of view. Where we differ from Dr. Schwaber is that we think there needs to be an oscillation between finding the patient's perspective and presenting an "outside" or alternative perspective to the patient, an essential component of mentalization-based therapy.

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#### Antidepressant Use and Preterm Birth

TO THE EDITOR: I would like to congratulate Katherine L. Wisner, M.D., et al. for their important study, published in the May 2009 issue of the *Journal*, on depression and antidepressant treatment in pregnant women (1). However, I have several concerns with the article.

The study appears to show that depressed pregnant women with either continuous depression or continuous selective serotonin reuptake inhibitor (SSRI) use have preterm birth rates >20%. However, these two groups are very different, and it seems that the authors did not adequately control for group differences. The group with continuous depression (no SSRI exposure) was more likely to be young, African

American, obese, unmarried, and of lower educational attainment. This group was also more likely to be using alcohol while pregnant and more severely depressed compared with the continuous SSRI exposure group. Perhaps most importantly, of the 14 women in the continuous depression group, there were four prior preterm births, while there were only six prior preterm births among the 48 women with continuous SSRI exposure.

Many of these differences between the two groups (e.g., African American race, low socioeconomic status, prior preterm birth) are risk factors for preterm birth, which must be controlled for. In the article, it does not appear that this was the case. Even without controlling for all of these factors, based on Table 4, it seems that only the continuous SSRI group had a statistically significant increase in the rate of preterm birth (a rate ratio of 5.43), with a confidence interval that did not cross 1.00.

These results are dramatic and join the accumulating evidence that now links SSRI use to preterm birth (2, 3). Pregnant women and their providers should be made aware of the growing evidence that supports an association between SSRI use and preterm birth.

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#### Dr. Wisner Replies

TO THE EDITOR: Dr. Urato is concerned that the group of pregnant women treated continuously with SSRIs was very different from the group of continuously depressed pregnant women and that we may not have adequately controlled for those group differences. Dr. Urato also states that many of these differences are risk factors for preterm birth and must be controlled for. The strategy for distributing confounding variables equally between groups is randomization. In an observational study, controlling for variables known to be associated with the outcome is an approach to address (but not resolve) this problem. We tested the variables identified by Dr. Urato in a multivariable model. Only maternal age significantly predicted shorter gestational length, and we controlled for race. We did not adjust for prior preterm birth in our model for SSRIs and current preterm birth because doing so may induce bias into the association between SSRI exposure and preterm birth in the index pregnancy (1). Conducting