Another concern is the selection of traumatic events. Accidents, sudden death of a loved one and witnessing violence are categorised as traumatic events but gave relatively low PTSD scores. In our opinion, such events may evoke a range of reactions such as guilt, anger, sadness, anxiety and apathy. Again, if criterion A2 – a response involving intense fear, helplessness or horror – has not been assessed, it is questionable whether these experiences were really traumatic.

The conclusion that life events can generate as many PTSD symptoms as traumatic events is unjustified. At most it could be concluded that some of the PTSD items might not be specific to trauma but are more general stress-related symptoms.

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Authors' reply: Drs de Bruijn & Denys are concerned about identification of PTSD in the absence of the A1 and A2 criteria of the DSM–IV. However, we did not diagnose PTSD but we looked at PTSD symptomatology related to the worst event experienced by participants (including traumatic and non-traumatic events). We did not include the A1 criterion because we wanted to investigate whether the 17 symptoms that are thought to typically occur in those who have experienced a traumatic event, as defined by DSM–IV, are indeed specific for that type of event or occur as frequently following non-traumatic events. In order to study this we inevitably chose events that did not fulfil the A1 criterion (otherwise we would not have had a control group of events). Regarding the A2 criterion, it would be interesting to study respondents' subjective appraisal of the event in terms of fear, helplessness and horror. This would clarify whether the A2 criterion is also as specific for traumas as is often argued and how it is related to the 17 B criteria of the DSM–IV. We would not be surprised if non-traumatic major events could also evoke the emotions of fear, helplessness and horror.

Drs de Bruijn & Denys were also concerned about the somewhat low specificity of the self-report scale we used to measure PTSD symptoms (the Post-traumatic Stress Symptom Scale – Self-Report version; Foa *et al*, 1993). However, it is conceivable that our results are owing to the lack of specificity of PTSD symptoms in general for diagnosing PTSD, as was demonstrated in a recent study by Gold *et al* (2005).

Concerning the results in Table 4: the traumatic events groups did score higher on several items (3 out of 17) but these differences were not significant, indicating that no specific items were more strongly related to traumatic events than to life events.

In summary, our main conclusion that life events can generate as many PTSD symptoms as traumatic events is upheld.

Declaration of interest

The Achmea Foundation for Victim Support in Society paid the salary of S.S.L.M. but had no influence on the methodology or analyses of the study.

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Psychiatric comorbidity and chronic fatigue syndrome

Prins *et al* (2005) assessed psychiatric comorbidity in chronic fatigue syndrome (CFS) using the Structured Clinical Interview for DSM–III–R. Comorbidity was remarkably low compared with similar investigations, and in particular the apparent absence of current post-traumatic stress disorder (PTSD) was striking. The authors speculated that the low comorbidity rates might result mainly from a lack of 'psychiatric bias' of the examiners. They also found that psychiatric comorbidity did not predict the outcome of cognitive–behavioural therapy.

Without doubt, diagnosing comorbid depression and anxiety disorders in CFS is useful because both are highly treatable emotional reactions to the illness. The relevance of somatoform disorders (such as somatisation disorder) for CFS is more doubtful, given their inherently dualistic character (Mayou *et al*, 2005). Most importantly, the very low lifetime incidence of PTSD reported by Prins *et al* (2005) emphasises the value of descriptive psychiatric diagnoses in CFS. In my experience many patients with CFS report victimisation during childhood and/or adult life, and this has been confirmed by a controlled questionnaire-based study (Van Houdenhove *et al*, 2001). However, most victimised patients have 'sub-threshold' symptoms that do not meet diagnostic criteria of clinical PTSD. It is important to listen carefully to the patient's life history (Van Houdenhove, 2002) in order to shed light on any aetiological role of traumatic experiences in CFS and the resulting personality disturbances that may negatively influence treatment.

In summary, psychiatric evaluation of patients with CFS should not be limited to establishing a diagnosis of psychiatric comorbidity but should first involve narrative strategies (Greenhalgh & Hurwitz, 1998).

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