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Original Article

Using point allocation to identify outcomes that matter: results from two cognitive behavioural therapy trials for depression

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Background

Depression trials typically use symptom-based outcomes to determine treatment efficacy. Qualitative work with service users and clinicians indicates that other outcomes may be equally or more important. Quantitative investigations are needed to assess the relative importance of outcomes to key stakeholders.

Aims

To examine how stakeholders (service users with minimal symptoms (Beck Depression Inventory Second Edition (BDI-II) score ≤18), those who were currently symptomatic (BDI-II score ≥19) and clinicians working with people with depression) prioritise outcome domains drawn from two completed trials of cognitive behavioural therapy (CBT) for depression. This was from a new sample of stakeholders in order to explore similarities, differences and predictors of domain importance.

Method

An online survey using a novel point-allocation method examined stakeholder priorities for outcome domains from two completed UK trials of CBT for depression. Stakeholder free-text responses explaining point allocations were thematically analysed. Multivariate analysis of covariance explored differences in domain importance across groups, and exploratory multivariate general linear models investigated predictive variables.

Results

In total, 229 participants completed the survey (57 with minimal symptoms, 108 who were currently symptomatic and 64 clinicians). Median point allocations suggest that all three participant groups assigned similar importance to depression symptoms, quality of life, anxiety symptoms and impact on activities. Sociodemographic factors significantly predicted domain importance within the currently symptomatic group, and age was a predictor both across and within this subgroup.

Conclusions

Stakeholders valued several outcome domains with similar importance. While depression symptoms are not unimportant to stakeholders, they are balanced with other outcomes, such as quality of life, that are rarely measured in depression trials. These findings demonstrate the need to incorporate stakeholder-important outcomes into trial design, with stakeholder-weighted composite outcomes offering a potential method to capture this broader judgement of benefit.

Keywords

Depression; randomised controlled trials; efficacy; outcomes; point allocation.

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Depression is a common but serious illness that affects many areas of an individual's life, including impairments in physical, occupational and social functioning.[1] By 2030, the World Health Organization predicts that depression will be a leading cause of disease burden worldwide.[2] In the UK, the recommended first-line treatment for mild-to-moderate depression is cognitive behavioural therapy (CBT), and for severe cases this is combined with an antidepressant.[3]

The efficacy of depression treatments is evaluated through randomised controlled trials (RCTs), with a primary outcome used to identify statistical or clinical improvement. Despite a range of possible primary outcomes, the most common are symptom-based.[4,5] However, qualitative research suggests that these symptom-based outcomes are not the most important to service users,[6] who frequently report the importance of social, daily and occupational functioning.[7]

Quantitative studies have attempted to assess outcome importance, but these have limitations.[8] Ranking methods can rank domains from most to least important, but they do not indicate how much more or less important each domain is.[9] Studies using direct ratings, such as Likert scales, have often found little variation, with many participants rating each domain as the most important.[10,11] A simple method that can overcome these limitations is a fixed-point allocation technique that assigns a total number of points between domains.[12,13]

Personal characteristics might affect the allocation of points. For instance, Stolker et al[12] found that service users' importance weights given to death as an outcome in cardiovascular studies varied significantly by age, income and ethnicity, while also differing from the weights assigned by clinicians. Clinical factors may also affect outcome value. In a quantitative survey of adults with depression, treatment goals changed between those experiencing their first episode and those with recurrent depression.[7] Another quantitative survey found that during acute depression, mood, physical and cognitive symptom outcomes were prioritised, whereas healthcare providers shifted towards functioning outcomes during remission.[14]

We know that demographic characteristics affect depression episodes[15,16] and treatment outcomes,[17,18] but they may also affect outcome importance as viewed by both clinicians and people with lived experience of depression. This information could be vital to the design of future trials and potentially to the re-evaluation of the benefits of depression treatments. We adopted the simple point-allocation method, not previously used in depression research, to

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assess outcome importance by capturing the distance in importance and relative trade-offs between domains.[8] This method aligns with the future construction of stakeholder-weighted composite outcomes. The outcomes in this study were drawn from two completed trials of CBT for depression (CLASSIC[19] and COBALT[20]), broadly reflecting outcomes commonly reported in depression trials.[5]

Importance ratings will be explored between those with lived experience and clinicians and will also, for the first time, evaluate whether stage of depression and sociodemographic characteristics affect priorities. This will provide quantitative data on outcomes that can be used for better trial design in the future.

Method

This cross-sectional survey compared domain importance data from three groups collected via an anonymous online survey. Two service user groups were stratified according to current depression severity: minimally symptomatic (Beck Depression Inventory Second Edition (BDI-II)[21] score $\leq$18) and currently symptomatic (BDI-II score $\geq$19). Clinical studies have used this BDI-II threshold to define those with minimal symptoms by combining the minimal and mild categories.[22] The third group were clinicians who regularly treat depression, including psychologists, mental health nurses and doctors.

All procedures contributing to this work comply with the ethical standards of the relevant national and institutional committees on human experimentation and with the Helsinki Declaration of 1975, as revised in 2013. Ethical approval was granted by the King's College London Research Ethics Committee (HR/DP-24/25-45410) and West Midlands South Birmingham Research Ethics Committee (25/WM/0067).

Participants and recruitment

Participants were recruited in the UK between February and October 2025 and were eligible if they were aged 18–75 years, reflecting the age eligibility of the original trials the domains were drawn from. Service users were eligible if they had lived experience of depression, and clinicians were eligible if they worked in a service user-facing role providing care for people with depression.

We recruited individuals who may not have been currently receiving care through charities and social media, as well as previous participants who had consented to future contact from two studies: Remote Assessment of Disease and Relapse-Central Nervous System (RADAR-CNS) and Genetics Links to Anxiety and Depression (GLAD). Clinicians and treatment-seeking service users were recruited via the local UK National Health Service (NHS) (South London and Maudsley NHS Trust) through team visits, posters and the research register. Including clinicians allowed comparisons between lived experience and practitioner perspectives on outcome importance. All interested participants received the participant information sheet and provided electronic written consent via Qualtrics. On completion, participants were offered a £5 Love2Shop voucher.

Measures

Context and grouping variables

Participants recruited through previous studies and the NHS had an established diagnosis of depression. Participants recruited from the community self-reported having depression. No diagnostic screening was conducted in this study; however, current symptom severity was assessed for all service user participants using the BDI-II.[21] All eligible respondents provided sociodemographic and clinical information, including age, ethnicity, gender, education, employment and relationship status. Service users reported current depression treatment and years since illness onset. Clinicians reported their role, years in role and managerial status.

Importance of domains

Two domain lists were drawn from the published reports of two completed UK-based RCTs (CLASSIC[19] and COBALT[20]). CLASSIC was a CBT-based day-group intervention, whereas COBALT evaluated 12–18 sessions of individualised CBT. CBT is the UK's first-line treatment for depression.[3] Point-allocation tasks become cognitively demanding with more than six to eight domains so we restricted the lists to domains published in the main papers to maintain feasibility.[23]

Fixed-point allocation task

Participants allocated 100 points across outcome domains, with higher scores indicating greater importance. If domains were of similar importance, they could assign the same points, but totals had to sum to 100 before submission. This method required consideration of relative trade-offs and addressed the limitations of direct rating and ranking methods.

Each participant completed the fixed-point allocation task twice, once for each domain list. The wording of domains was standardised (Table 1) and presented in a fixed order (CLASSIC followed by COBALT). These trials represent recognised, ethically scrutinised outcome sets that influence practice and policy. It is unknown how stakeholders prioritise these domains relative to one another. Service users have reported that their experiences of CBT are too generalised[24] and lack individualisation because the outcomes assessed do not reflect their priorities.[25] All analyses were conducted separately for the CLASSIC and COBALT domain lists because they used non-identical domain sets that could not be harmonised for pooled analysis. This allowed comparison of shared domains while examining how stakeholder valuations depended on the specific domain sets presented.

After completing the fixed-point allocation tasks, participants were invited to respond to two optional free-text boxes to explain their point allocations and suggest any missing domains.

Data analysis

Compositional point-allocation data were analysed using an isometric log ratio (ILR) transformation to enable parametric analysis, avoid multicollinearity and produce orthogonal coordinates.[26,27] Sequential pivot ILR balances were computed separately for each outcome list.

To assess whether the fixed ordering of domains produced an anchoring effect, where participants allocated more points to earlier-listed domains, we fitted simple linear regression models predicting points allocated from item position. A negative association would indicate anchoring, with earlier items receiving more points, whereas a positive association would indicate the opposite with later-listed domains receiving more points. A non-significant regression coefficient would suggest no statisically significant relationship between item position and points allocated.

All analyses were performed using SPSS Statistics version 31 for Windows (IBM Corp, Armonk, New York, USA; https://www.ibm.com/products/spss-statistics).

Analyses were based on complete cases because there were minimal missing sociodemographic and clinical data (0–2 participants per group). The fixed-point allocation task had no missing data. Sample sizes for each analysis are reported in the Supplementary Material available at https://doi.org/10.1192/bjp.2026.10765.

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Table 1 Trial outcome lists

CLASSIC[19]	COBALT[20]
Reduce symptoms of depression (Beck Depression Inventory-II (BDI-II))	**Reduce symptoms of depression (BDI-II)**
Reduce symptoms of anxiety (General Anxiety Disorder-7 (GAD-7))	Reduce symptoms of anxiety (GAD-7)
Improve self-esteem (Rosenberg Self-esteem Scale)	Reduce feelings of panic (Primary Care Evaluation of Mental Disorders (PRIME-MD))
Satisfaction with treatment (Client Satisfaction Questionnaire (CSQ))	Remission from symptoms of depression (BDI-II)
Reduce service use (Client Service Receipt Inventory (CSRI))	Less impact on daily activities due to mental health problems (Short Form-12 Health Survey Mental Subscale (SF-12))
Increase employment (CSRI)	Less impact on daily activities due to physical health problems (Short Form-12 Health Survey Physical Subscale (SF-12))
Greater quality of life (EuroQoL-5 Dimension (EQ-5D))	

Note: Bold indicates the primary outcome of the original trial. Participants were presented with a brief summary for each domain. The measure shown in parenthesis (e.g. BDI-II) is included to indicate the corresponding trial measure and was not shown to participants.
A version of this table including full citations for all outcome measures is provided in Table S1.
Fixed presentation order.
CLASSIC: Reduce service use, increase employment, reduce symptoms of depression, reduce symptoms of anxiety, improve self-esteem, satisfaction with treatment, greater quality of life.
COBALT: Reduce symptoms of depression, remission from symptoms of depression, less impact on daily activities due to mental health problems, less impact on daily activities due to physical health problems, reduce feelings of panic, reduce symptoms of anxiety.

Descriptive analysis

Sociodemographic and clinical characteristics were summarised using descriptive statistics, including *N* and percentages. The mean, s.d. and median were calculated to describe the relative share of participants' total points allocated to each domain as compositional data rather than as independent scores.

Comparative analysis

Given the interdependence of the dependent variables, multivariate analysis of covariance (MANCOVA) was used as the primary inferential analysis to examine group differences in outcome importance. The dependent variables were the ILR-transformed point allocations for each domain, and participant group was the independent variable. Models controlled for covariates available across all participants, including age, gender and ethnicity. *Post hoc* univariate analyses and bootstrapped parameter estimates were considered exploratory.

Predictive analysis

To explore which individual characteristics predicted variation in outcome importance, exploratory multivariate general linear models were fitted. Models for the full sample included the shared covariates of age, gender and ethnicity. Group-specific models additionally included service user variables (employment, current care, estimated years lived with depression and first episode of depression) and clinician variables (current NHS band, managerial status and years in role).

All models were bootstrapped (1000 folds), with statistical significance defined as a 95% bootstrapped confidence interval excluding zero. The Holm–Bonferroni procedure was used to control the family-wise error rate by sequentially adjusting significance thresholds for multiple comparisons.[28]

Qualitative analysis

Responses were analysed using Braun and Clarke's thematic analysis[29] in NVivo15 version 15 for Windows (Lumivero, Denver, Colorado, USA; https://lumivero.com/products/nvivo/2025). At least two coders independently completed each stage, reaching consensus before progressing: familiarising with the data, generating initial codes, collating codes into themes, reviewing themes and defining and naming themes.

A proportionate random subsample of survey completers was invited to independently review the draft thematic findings. Twenty service users and 8 clinicians were invited (12% of each group), and 13 responded (10 service users and 3 clinicians; 46% overall response rate). Feedback was collected via an anonymous survey, with another £5 Love2Shop voucher offered on completion. Themes were refined in response to this feedback aiming to improve their accuracy and relevance.

Patient and public involvement

The proposed research was presented to an National Institute for Health and Care Research (NIHR) Maudsley Biomedical Research Centre (BRC) Service User Advisory Group (SUAG) for consultation during study development. In addition, the NIHR Maudsley's BRC Feasibility and Acceptability Support Team for Researchers (FAST-R) reviewed and provided feedback on the study protocol and participant-facing documents. An advisory group of adults with lived experience of depression collaborated with the analysis, interpretation and critical review of the manuscript including a lay summary (Supplement P2). People with lived experience are co-authors of this manuscript.

Results

A total of 229 participants completed the survey (57 service users with minimal symptoms, 108 currently symptomatic service users and 64 clinicians). Sociodemographic and clinical characteristics are presented in Table 2.

Across all groups, participants distributed points across multiple domains rather than prioritising a single domain. Allocations were concentrated across three to four domains (depression symptoms, anxiety symptoms, functioning/activities (where included) and quality of life). Differences between groups were modest.

Descriptive analysis

No primacy anchoring was observed. There was a small positive association between list position and points allocated (Table S4; CLASSIC $R^2 = 0.061$, $F(1, 1601) = 103.750$, $p < 0.001$; COBALT $R^2 = 0.174$, $F(1, 1372) = 289.509$ $p < 0.001$), indicating that later-listed domains tended to receive slightly higher allocations. However, the effect was small.

Table 3 presents the mean and median raw points, reflecting the relative share of participants' total points assigned to each domain within each group. In the CLASSIC domain list, depression symptoms received the highest mean allocation in the minimally symptomatic group (mean = 26.23, s.d. = 16.15, median = 20.00)

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Table 2 Demographic information

Demographic variables	Minimal symptoms *n* (%)	Currently symptomatic *n* (%)	Clinicians *n* (%)
Age			
Mean (s.d.)	49.93 (15.06)	41.44 (14.42)	–
Median (IQR)	–	–	31.00 (9.00)
Gender			
Women	38 (67.9)	70 (65.4)	52 (81.3)
Ethnicity			
White	40 (70.2)	78 (72.9)	42 (66.7)
Other	17 (29.8)	29 (27.1)	21 (33.3)
Relationship status			
No relationship	29 (52.7)	61 (58.1)	26 (41.3)
Education			
Secondary or below	12 (21.1)	45 (42.1)	1 (1.6)
Undergraduate	26 (45.6)	43 (40.2)	17 (26.6)
Postgraduate	19 (33.3)	19 (17.8)	46 (71.9)
Employment			
Paid employment	38 (66.7)	53 (50.0)	63 (98.5)
BDI score			
Mean (s.d.)	7.8 (5.6)	33.1 (10.4)	–
Current care			
Medication	23 (40.4)	45 (41.7)	–
Therapy	6 (10.5)	9 (8.3)	–
Combination	3 (5.3)	30 (27.8)	–
None	25 (43.9)	24 (22.2)	–
First depression episode			
Yes	13 (22.8)	23 (21.3)	–
Estimated years with depression			
Median (IQR)	10.00 (17.0)	13.50 (22.0)	–
Estimated years in role			
Median (IQR)	–	–	4.00 (4.0)
NHS band			
≤Band 6	–	–	39 (60.9)
≥Band 7	–	–	25 (39.1)
Manager			
Yes	–	–	9 (14.1)
Total	57 (100.0)	108 (100.0)	64 (100.0)

Total *n* may not sum to 229 due to missing data.
Median and IQR are presented for skewed continuous variables. No missing cases for BDI-II score.
BDI, Beck Depression Inventory; IQR, interquartile range; NHS, National Health Service.

Table 3 Mean and median points assigned to outcome domains within stakeholder groups

	Minimal symptoms ($n = 57$)		Currently symptomatic ($n = 108$)		Clinicians ($n = 64$)	
Outcome list	Mean (s.d.)	Median	Mean (s.d.)	Median	Mean (s.d.)	Median
CLASSIC						
Quality of life	21.91 (14.44)	20.00	19.18 (13.96)	20.00	22.38 (9.04)	20.00
Depression symptoms	26.23 (16.15)	20.00	22.31 (13.96)	20.00	20.19 (8.05)	20.00
Symptoms of anxiety	20.95 (14.22)	20.00	18.91 (12.63)	20.00	15.09 (5.23)	15.00
Self-esteem	14.88 (9.68)	15.00	15.97 (9.03)	17.00	15.39 (6.60)	15.00
Satisfaction with treatment	7.74 (8.20)	5.00	8.32 (7.95)	5.00	10.52 (5.47)	10.00
Service use	3.65 (5.28)	0.00	6.53 (8.89)	5.00	6.55 (3.97)	5.00
Employment	4.65 (6.50)	0.00	8.79 (12.23)	5.00	9.88 (5.54)	10.00
COBALT						
Depression symptoms	21.39 (14.29)	20.00	21.22 (12.64)	20.00	21.25 (8.44)	20.00
Depression remission	23.00 (18.02)	20.00	16.61 (9.92)	20.00	16.88 (7.59)	20.00
Impact on activities (mental)	21.09 (16.19)	20.00	19.56 (11.60)	20.00	21.02 (8.48)	20.00
Anxiety symptoms	19.02 (12.06)	20.00	17.43 (12.00)	15.00	14.66 (6.02)	15.00
Panic symptoms	9.67 (10.48)	10.00	14.20 (12.35)	10.00	12.67 (7.53)	15.00
Impact on activities (physical)	5.84 (7.66)	0.00	10.98 (9.47)	10.00	13.53 (7.26)	11.50

Mean, s.d. and median values represent the relative share of participants' total points assigned to each outcome domain as compositional data, rather than independent scores. Participants assigned a total of 100 points; therefore, these values should be interpreted as proportions within a constrained whole, not as standalone quantities.
Descriptions of top and joint top domain choices are provided in Tables S2–S3.
Fixed presentation order.
CLASSIC: Reduce service use, increase employment, reduce symptoms of depression, reduce symptoms of anxiety, improve self-esteem, satisfaction with treatment, greater quality of life.
COBALT: Reduce symptoms of depression, remission from symptoms of depression, less impact on daily activities due to mental health problems, less impact on daily activities due to physical health problems, reduce feelings of panic, reduce symptoms of anxiety.

and the currently symptomatic group (mean = 22.31, s.d. = 13.96, median = 20.00). Clinicians prioritised quality of life (mean = 22.38, s.d. = 9.04, median = 20.00), followed closely by depression symptoms (mean = 20.19, s.d. = 8.05, median = 20.00).

For the COBALT domain list, depression symptoms received the highest mean allocation in the currently symptomatic group (mean = 21.22, s.d. = 12.64, median = 20.00) and among clinicians (mean = 21.25, s.d. = 8.44, median = 20.00). Minimally

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symptomatic participants prioritised depression remission (mean = 23.00, s.d. = 18.02, median = 20.00).

As the point-allocation data were ILR transformed, each ILR balance contrasted one domain with the geometric mean of preceding domains. Positive coefficients indicate greater relative importance of the subsequent domain, whereas negative coefficients indicate greater relative importance of the contrasted domain (see Table S5 for interpretative guidance).

Comparative analysis

Assumption checks indicated violations of homogeneity and multivariate normality so Pillai's Trace was used. The MANCOVA showed that stakeholder groups differed in their overall pattern of point allocations across domains, with the small–moderate multivariate between-group effects that were stronger for the COBALT domain list than for the CLASSIC domain list (Table S6).

For the CLASSIC domain list, univariate tests revealed significant overall group differences for depression symptoms relative to service use and employment ($F(2, 219) = 8.995$, $p < 0.001$, partial $\eta^2 = 0.076$), and for anxiety symptoms relative to service use, employment and depression symptoms ($F(2, 219) = 5.691$, $p = 0.004$, partial $\eta^2 = 0.049$) (Table S7).

Bootstrapped parameter estimates for the minimally symptomatic group did not remain significant after Holm–Bonferroni correction (Table S8). Clinicians placed significantly less importance on depression symptoms relative to service use and employment ($B = 0.990$, 95% CI 0.317–1.736, $p = 0.007$) than the currently symptomatic group. Clinicians also placed less importance on anxiety symptoms relative to depression symptoms, service use and employment ($B = 0.837$, 95% CI 0.272–1.469, $p = 0.007$) compared with the currently symptomatic group.

For the COBALT domain list, univariate tests revealed significant group differences for depression symptoms, depression remission and the impact on activities (mental) relative to the impact on activities (physical) ($F(2, 219) = 12.820$, $p < 0.001$, partial $\eta^2 = 0.105$), and for anxiety symptoms relative to all preceding domains ($F(2, 219) = 5.342$, $p = 0.005$, partial $\eta^2 = 0.047$). Bootstrapped parameter estimates showed that the minimally symptomatic group assigned greater relative importance to depression symptoms, depression remission and the impact on activities (mental) relative to the impact on activities (physical) than the currently symptomatic group ($B = 2.153$, 95% CI 0.894–3.503, $p < 0.001$), whereas clinicians assigned less importance to these outcomes relative to the impact on activities (physical) than the currently symptomatic group ($B = -1.000$, 95% CI −1.753–0.259, $p = .007$). Estimated marginal means (EMMs) and EMM pairwise comparisons are presented in Tables S9–S10.

Predictive analysis

Detailed tables are provided in the Supplementary Material (Tables S11–S22).

Between-group effects

Predictive analyses examined whether individual characteristics predicted variation in point allocations across the full sample. Age showed significant multivariate effects for both outcome lists (CLASSIC: Pillai's Trace = 0.191, $p < 0.001$; COBALT: Pillai's Trace = 0.097, $p < 0.001$), indicating small–moderate multivariate effects. So age predicted relative outcome importance irrespective of participant group.

For the CLASSIC domain list, age significantly predicted how participants prioritised symptoms of depression relative to service use and employment outcomes ($F(1, 221) = 49.967$, $p < 0.001$, partial $\eta^2 = 0.184$), and anxiety symptoms relative to depression symptoms, service use and employment ($F(1, 221) = 13.806$, $p < 0.001$, partial $\eta^2 = 0.059$). Bootstrapped parameter estimates showed that older participants placed significantly greater relative importance on depression symptoms relative to service use and employment compared with younger participants ($B = -0.097$, s.e. = 0.014, $p < 0.001$, 95% CI −0.126–0.069). Older participants also placed significantly less relative importance on depression symptoms, service use and employment than on anxiety symptoms compared with younger participants ($B = -0.046$, s.e. = 0.014, $p = 0.002$, 95% CI −0.073–0.018).

For the COBALT domain list, age significantly predicted how participants prioritised depression symptoms, depression remission and the impact on activities (mental) relative to the impact on activities (physical) ($F(1, 221) = 6.684$, $p = 0.010$, partial $\eta^2 = 0.029$), and panic symptoms relative to all previous outcomes ($F(1, 221) = 9.639$, $p = 0.002$, partial $\eta^2 = 0.042$). Bootstrapped parameter estimates showed that older participants assigned greater relative importance to the previous domains than to panic symptoms compared with younger participants ($B = 0.046$, s.e. = 0.016, $p = 0.007$, 95% CI 0.015–0.078).

Within-group effects

Next, predictive analyses examined whether individual characteristics predicted variation in point allocations within each stakeholder group.

Minimal symptoms group

The multivariate test did not reach statistical significance for either outcome list, indicating that sociodemographic and clinical factors did not predict the relative importance assigned to domains.

Currently symptomatic group

Several sociodemographic factors predicted domain importance with small–moderate multivariate effects. Significant multivariate effects were found for age (CLASSIC: Pillai's Trace = 0.239, $p < 0.001$; COBALT: Pillai's Trace = 0.203, $p = 0.001$) and education (CLASSIC: Pillai's Trace = 0.150, $p = 0.025$; COBALT: Pillai's Trace = 0.128, $p = 0.031$). For COBALT, estimated years with depression also showed a significant multivariate effect (Pillai's Trace = 0.130, $p = 0.029$).

For CLASSIC, age significantly predicted greater importance placed on depression symptoms relative to service use and employment ($F(1, 92) = 24.418$, $p < 0.001$, partial $\eta^2 = 0.210$), with older participants assigning significantly more importance to depression symptoms relative to service use and employment outcomes ($B = -0.130$, 95% CI −0.175–0.071, $p < 0.001$).

Education predicted the importance assigned to anxiety symptoms relative to service use, employment and depression outcomes among those with postgraduate-level education ($F(1, 92) = 10.004$, $p = 0.002$, partial $\eta^2 = 0.098$), with postgraduate participants placing significantly less importance on anxiety symptoms relative to previous outcomes than those with an undergraduate education ($B = 2.440$, 95% CI 0.914–4.071, $p = 0.005$).

For COBALT, significant univariate effects of age and education were found. However, bootstrapped parameter estimates did not survive Holm–Bonferroni correction.

Clinicians

For CLASSIC, multivariate tests indicated significant overall effects of age and estimated years in role; however, no univariate effects survived Holm–Bonferroni correction.

For COBALT, the multivariate test did not reach statistical significance, indicating that sociodemographic and professional characteristics did not predict the relative importance of outcomes.

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Qualitative results

Tables S23–S24 provide further information on the qualitative results.

Question 1 – 'Could you please briefly describe any reasons for the points you assigned above?'

Participants' explanations for their point allocations complemented the quantitative results (Table 4). Some described a clear hierarchy of importance, whereas others viewed several outcomes as equally important, reflected by assigning equal points (Theme 1). This was consistent with the tied median point allocations across multiple domains.

Some participants prioritised symptom reduction or remission by assigning more points, considering these outcomes to be the foundation and prerequisites for improvement in other outcomes (Theme 2). This perspective was evident in the minimal symptom group, which had among the highest mean point allocations for symptom- and remission-based outcomes in both outcome lists.

Other participants emphasised day-to-day functioning or quality of life as the key outcome, with some expressing this particularly when remission or recovery would be unachievable (Theme 3). Some clinicians also recognised this emphasis among their service users.

Anxiety and panic symptoms varied in importance (Theme 4). Some participants described them as central to their depression and allocated more points to them, while others reported experiencing fewer anxiety symptoms, so assigned fewer points. Clinicians generally regarded anxiety as secondary to the primary treatment focus of depression symptoms, reflected by clinicians assigning fewer median points to anxiety-based outcomes in both datasets.

Question 2 – 'Are there any treatment outcomes not described above that would be important to your treatment?'

Participants emphasised outcomes related to identity, emotional stability and sense of purpose, describing the importance of feeling connected, hopeful and able to cope with challenges. There was strong emphasis across all groups on relational and social outcomes, such as rebuilding or creating new relationships and feeling socially connected through activities such as clubs. All groups highlighted the value of gaining skills and understanding of their mental health to recognise and manage future symptom recurrence.

Discussion

This study found both similarities and differences in how outcomes from two exemplar CBT trials were valued. Although RCTs predominantly assume that a single primary outcome reflects trial success,[30] no group in our study prioritised a single domain. Instead, participants distributed points across multiple domains, challenging the assumption that depression symptoms alone can adequately capture treatment benefit. Our findings complement applied multi-criteria decision modelling (MCDM) work, such as Zhang et al,[31] which examines the effects of applying weights such as these to trial data.

Average points allocated

Depression symptoms received high but similar mean point allocations to other domains, with wide standard deviations revealing that some individuals assigned considerably more points to depression symptoms and others far fewer. The fixed-point allocation task required participants to make explicit trade-offs, meaning this variability reflects differences in what participants considered most important. The qualitative findings help explain this variability, with some participants framing symptom reduction or remission as central, whereas others emphasised living well with ongoing symptoms.

Median point allocations, which are less sensitive to outliers, revealed broad consensus across groups. In both lists, the top-rated domains received a median of 20 points, indicating that no single domain was judged to be solely the most important. This challenges the assumption that symptom change alone captures treatment benefit and supports a more holistic approach that recognises multiple domains as important.[32]

Differences in the importance of depression symptoms

Depression symptoms appeared in both lists but were valued differently across groups. In CLASSIC, clinicians assigned significantly less importance to depression symptoms than currently symptomatic participants, relative to service use and employment. In COBALT, clinicians again assigned lower importance to depression symptoms, remission and impact on activities due to mental health, relative to impact on activities due to physical health, than currently symptomatic participants. This reflects the relative trade-off created by the fixed-point task. Although depression symptoms were present in both trials, the surrounding domain sets differed, shaping the relative comparisons made. Overall, clinicians placed relatively less importance on depression symptoms across both trials compared with currently symptomatic participants, but the expression of this pattern depended on the competing domain sets presented.

Do sociodemographic factors affect outcome importance?

Only the sociodemographic and clinical factors within the currently symptomatic group significantly predicted outcome importance, the group generally recruited into clinical trials as participants. Few quantitative studies have examined stakeholder outcome priorities.[7] Currently symptomatic service users with a postgraduate education placed less relative weight on anxiety symptoms. This aligns with broader evidence that sociodemographic factors, including education, shape mental health-related priorities and help-seeking behaviours.[33]

Older adults consistently prioritised depression symptoms over functional outcomes such as employment, likely reflecting life-stage differences in roles, expectations and concerns. Little research has explored age-related differences in outcome priorities among adults with depression, highlighting a gap for future research.[34] Evidence from other areas shows that age shapes mental health-related priorities, such as younger adults' greater preference for internet-based interventions.[35] Younger adults placed greater importance on panic than older adults, consistent with evidence that younger adults report increased psychological distress linked to stressors like financial stress.[36] As younger adults are less likely to benefit from psychological interventions,[37] relying solely on depression symptom primary outcomes may underrepresent treatment benefit for this group.

Gaps in trial outcome sets

Unlike the variability seen for depression symptoms, quality of life in the CLASSIC list did not differ significantly across stakeholder groups, with all groups assigning a median score of 20 points, making it a highly valued outcome. This aligns with qualitative

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Table 4 Themes from qualitative questions with example quotes

Theme	Definition	Example quotes
Question 1: Could you please briefly describe any reasons for the points you assigned above?		
1. Diversity of perspectives on outcome hierarchy	Participants explained their point allocations using different underlying logics. Some described a clear hierarchy of outcomes, assigning more points to what they saw as foundational or most urgent. Others allocated equal points across several domains to emphasise that these outcome domains were equally important or interdependent to them. These reflect diverse ways of reasoning about outcome importance rather than a single shared ordering of outcomes.	'Reducing symptoms and impact of depression/low mood is always the main goal. Other outcomes such as increased employment/self-esteem are likely to follow but are not the main aim' **(clinician)** 'Quality-of-life and ability to carry out daily tasks are the main goals of medication and therapy for me. So, I gave them 50% of the overall score to show their importance' **(currently symptomatic)** 'Treatment of depressive symptoms would be my primary goal, but self-esteem is very much a part of depression for me, so I give it the same weight' **(minimal symptoms)**
2. Remission and recovery from symptoms of depression	Participants who allocated more points to symptom reduction or remission explained that these outcomes represented the clearest signs of getting better. Some viewed full remission as ideal, whereas others felt symptom reduction was a realistic step towards full recovery when full remission felt less achievable. Their reasoning for their point allocations centred on the belief that changes in symptoms would enable improvements in other outcome areas.	'Fundamentally I'm trying to enhance how someone feels so their symptoms of their disorder. Slightly less important is what knock-on effects this has: can I do more activities, can I work etc' **(clinician)** 'My reasons for my scoring are the need to deal with and manage depression and its symptoms, whereas I feel the other topics are essential, but I gave the highest scores in dealing with depression' **(currently symptomatic)** 'Remission of depression would be the ideal outcome as all others would come naturally with that. Reduction of symptoms would be next as that is why you generally seek treatment' **(minimal symptoms)**
3. Living well with depressive symptoms	Participants who assigned higher points to functioning or quality-of-life outcomes explained that they did so because they did not view full remission as achievable. Their point allocations reflected a pragmatic focus on managing daily life, maintaining routines and finding enjoyment despite ongoing symptoms. They prioritised outcomes that would help them live well with depression rather than trying to eliminate it entirely.	'Remission from symptoms may be unrealistic and therefore time should not be wasted on this goal, rather focusing on improved quality-of-life and self-esteem' **(clinician)** 'It is more important to me that my daily quality-of-life is improved, and that I can function better with less impact from my mental health issues, than aim for what feels unrealistic: complete recovery. I've had mental health issues most of my life, and I imagine I will for the rest of it and I'm okay with that. I'd just like to make it so that the damage they cause is less, and I'm happier living life with those issues in the background' **(currently symptomatic)** 'As someone with long term depression it's more important that I feel better able to contend with it and lessen the impact on the rest of life than remission' **(minimal symptoms)**
4. Anxiety as a key component of the experience of 'depression'	Participants explained their point allocations for anxiety outcomes by describing how central anxiety was to their experience of depression. Some assigned higher points because anxiety felt inseparable from, or more disruptive than, depression. Others allocated fewer points because anxiety was not a major feature of their depression or because they viewed the focus of treatment as being specifically on depression. This highlights the variability in how depression and anxiety co-occur and how this shaped participant prioritisation of outcomes.	'I think the key is reduce the symptoms of depression first and if clients are able to maintain this, longer term self-esteem and quality of life will improve. A lot of anxiety symptoms comes in depression, so it is important to prioritise treatment the depression' **(clinician)** 'I don't really experience as much anxiety as I do symptoms of depression' **(currently symptomatic)** 'Reducing the symptoms of anxiety greatly improves my ability to leave the house & to socialise. Depression often sits quietly in the background, always there but not as debilitating as episodes of anxiety' **(minimal symptoms)**
Question 2: Are there any treatment outcomes not described above that would be important to your treatment?		
1. Rebuilding a sense of self and purpose	Participants described outcomes related to identity, meaning and personal direction that were not captured in the task domains. They emphasised wanting to feel useful, rediscover their purpose, rebuild confidence in who they are and regain a sense of hope. These outcomes reflected deeper shifts in self-identity and meaning that were viewed as central to recovery.	'Able to manage grief of lost time to depression' **(clinician)** 'Feeling useful and having a purpose' **(minimal symptoms)** 'Feeling life is worthwhile, feeling like one has an identity and sense of self, finding purpose, finding some enjoyment again when anhedonia has become a major factor of depression, feeling there is a point to "being"' **(currently symptomatic)**
2. Emotional well-being, stability and resilience	Participants highlighted the importance of emotional steadiness and the ability to cope with challenges, distinct from symptom reduction. They described wanting to feel more balanced and able to manage future difficult moments. These outcomes reflect a desire for emotional resilience and a sense of internal stability beyond alleviating symptoms of depression or anxiety.	'I feel able to get myself out of any anxious or depressive episodes but sometimes it gets tiring to have keep telling myself that things aren't as bad as they seem' **(minimal symptoms)** 'I just want to feel happy with my life as far as possible and have the resilience to deal with things that cause unhappiness. I never had this problem before' **(currently symptomatic)**

(Continued)

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Table 4 (*Continued*)

Theme	Definition	Example quotes
3. Connection, belonging and social participation	Participants identified relational and social outcomes that were not included in the task domains. They emphasised rebuilding relationships, feeling connected to others and having a sense of belonging.	'Engaging with community groups again e.g. clubs, groups, events, church etc' **(clinician)** 'I want to know that I am engaged, involved and participating in life and in my communities' **(minimal symptoms)** 'I would say improved interpersonal relationships. Depression has ruined my love life' **(currently symptomatic)**
4. Empowerment through psychoeducation and therapeutic skills	Participants valued outcomes related to gaining insight, tools and strategies that would help them manage their mental health in the future. This included recognising early signs of relapse, feeling more confident in navigating difficulties and developing skills for long-term self-management. This reflects a desire for empowerment and sustained autonomy.	'Self-management of symptoms (i.e. learnt CBT skills applied by self at later date if symptoms recur)' **(clinician)** 'Greater understanding of my own mental health and living with it and managing it, therefore being able to manage a condition rather than seek its disappearance' **(minimal symptoms)** 'Learning self-reliant skills is important so I feel I can help myself when services inevitably end' **(currently symptomatic)**

findings and supports arguments that psychotherapies should target quality of life alongside symptoms.[38] However, a review of 450 depression trials found that the EuroQol 5-Dimension questionnaire (EQ-5D), the most frequently used quality-of-life measure, was a primary endpoint in 1% of trials and a secondary endpoint in 7%.[5] Participants suggested additional important domains beyond those included in the domain lists, such as social participation and emotional well-being (Table 4). Some of these, such as social functioning, overlap with previous literature,[67] but are also infrequently reported as trial outcomes.[5] Our findings highlight a disconnect between stakeholder priorities and current trial practice, emphasising the need to integrate stakeholder priorities into outcome selection to capture stakeholder-important treatment benefits.

Strengths and limitations

This study demonstrates the feasibility of a novel quantitative approach to measuring the importance of outcome domains in depression. However, several limitations should be considered. The online survey may have introduced biases related to computer access and literacy. Domains were presented in a fixed order. Although the task was brief and no anchoring effects were identified, framing or order effects remain possible. Future trials could randomise domain order to mitigate this.

The analysis plan was not preregistered, but analyses followed a consistent compositional data framework with standard diagnostic checks. Bootstrapped parameter estimates and Holm–Bonferroni corrections were applied to reduce the risk of false-positive findings, but the number of analyses conducted means that some smaller associations may still reflect chance. The BDI-II has been criticised for covering only 39% of domains considered important by service users.[5] No co-developed, depression-specific outcome measure currently exists,[39] highlighting an area for future development.

This study is based on domains from two UK-based CBT trials and may not be generalisable to other depression trials, although many psychological and pharmacological studies use similar outcomes (e.g. symptoms of depression, functioning and anxiety symptoms).[5] Outcome weights are likely to be context- and population-specific and may not generalise to all people with depression. However, this study identified sociodemographic predictors, such as age, and provides empirical evidence that stakeholder-derived weights can be feasibly elicited and applied, supporting future incorporation of stakeholder-prioritised weighting into trials.

All participants were UK-based. Despite a relatively large sample, some demographic categories (e.g. ethnicity) were collapsed to ensure sufficient cell sizes, potentially obscuring further subgroup variation. The advisory group reviewed variables and recommended that some (e.g. current care) not be collapsed despite small numbers. Sensitivity checks confirmed model stability. Larger samples would allow more granular subgroup analysis in future work.

Future directions

These findings challenge the assumption that a single primary outcome adequately captures treatment benefit. While the study identified stakeholder priorities, it also supports the development of stakeholder-weighted composite outcomes that may help balance funder-required and stakeholder-valued outcomes. These could offer a more nuanced alternative by combining multiple domains into a single score that reflects stakeholder priorities. Our results suggest that stakeholders judge symptom-based outcomes as important but also value broader domains of treatment benefit. Future work should test the feasibility of applying these stakeholder-weighted composites in mental health trials, building on existing initiatives to incorporate patient-important outcomes.

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Supplementary material

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Data availability

The data, analytic code and materials associated with this study, including survey instruments and coding frameworks, are available from the corresponding author, N.M., upon reasonable request.

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N.M. contributed to conceptualisation, methodology, data collection and preparation, quantitative data analysis, qualitative data analysis, writing of the original draft and writing – critical review and editing. T.W. contributed to conceptualisation, methodology, quantitative data analysis, writing – critical review and editing. T.W. and H.J. contributed to supervision. K.B., R.H., K.M. and H.J. contributed to quantitative data analysis and writing – critical review and editing. H.F., A. Madigan, M.M. and A. Mitchell contributed to qualitative data analysis and writing – critical review and editing. All authors read and approved the final manuscript.

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Declaration of interest

None.

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