THE PSYCHOLOGICAL BURDEN OF COMPENSATION AND CIVIL LITIGATION

A Continuing Education Reading Manual for Licensed Psychologists and Graduate-Level Clinicians

---

Compensation-Related Stress, Mental Health Sequelae, and Long-Term Disability Following Injury and Civil Litigation

A Comprehensive Reading Manual for Continuing Education

Prepared for Licensed Psychologists, Clinical Psychologists, Counseling Psychologists, and Advanced Graduate Trainees in Applied Psychology

---

ABSTRACT

This continuing education manual synthesizes an emerging body of empirical and theoretical work examining the psychological consequences of engaging with compensation and civil litigation systems following personal injury. Drawing on longitudinal cohort research (O'Donnell et al., 2015; Grant et al., 2014), a systematic meta-analysis of prospective studies (Elbers et al., 2013), and clinical-scholarly analysis of the litigant-patient (Strasburger, 1999), the manual advances an integrated conceptual framework in which the process of seeking compensation—not merely the injury itself—operates as a chronic psychosocial stressor that shapes mental health trajectories and long-term disability. The manuscript articulates how posttraumatic stress, depressive, and anxiety symptomatology emerging in the acute post-injury period may amplify a claimant's perception of the claims process as stressful, and how compensation-related stress in turn contributes independently to functional disability, diminished quality of life, and prolonged psychological distress. Mechanisms including diminished resources for stress management, procedural injustice, secondary victimization, and disruption of normative psychological defenses are examined. The manual also

addresses the clinical challenges of treating the litigant-patient, including transference and countertransference phenomena, boundary maintenance, documentation, and the tension between therapeutic and forensic frames. Areas of methodological disagreement, limitations of the existing evidence base, and future research priorities are discussed. The manual concludes with detailed clinical implications for psychologists, including recommendations for early screening, stepped-care intervention, procedural literacy, and system-level advocacy.

---

1. INTRODUCTION

Injury remains one of the largest contributors to the global burden of disease, accounting for approximately 12% of disability-adjusted life years worldwide and projected to account for one in five healthy life-years lost by 2020 (O'Donnell et al., 2015). Beyond its physical toll, injury exerts profound psychological consequences, with a substantial minority of survivors developing posttraumatic stress disorder (PTSD), major depressive disorder, anxiety disorders, and enduring functional disability. In many high- and middle-income countries, individuals injured in the two most common contexts—road traffic and workplace accidents—are eligible to access compensation schemes designed, at least ostensibly, to restore them to their preinjury state of health, function, and economic participation (Grant et al., 2014).

Yet across an extensive literature spanning several decades, a paradox has emerged. Claimants to compensation schemes consistently demonstrate worse health outcomes than injured individuals whose injuries fall outside such schemes, a finding replicated across meta-analyses of surgical outcomes, whiplash-associated disorders, orthopedic trauma, and mental health sequelae (Elbers et al., 2013; O'Donnell et al., 2015). This inverse relationship between compensation seeking and recovery has generated vigorous debate. Traditional explanations invoked the concept of "secondary gain," positing that compensation creates an unconscious financial incentive to remain ill. More recent scholarship, however, has begun to reconceptualize the compensation experience itself as a source of psychological injury—a chronic, adversarial, procedurally complex stressor superimposed on the physical and psychological wounds of the original trauma (Grant et al., 2014; Strasburger, 1999).

This reading manual is designed to equip psychologists with a scholarly, clinically actionable understanding of the psychological effects of compensation and civil litigation. The material integrates prospective cohort findings, meta-analytic synthesis, and clinical observation into a coherent narrative appropriate for advanced practitioners. Psychologists in health, rehabilitation, trauma, forensic, and general clinical settings routinely encounter individuals whose functional trajectories are being shaped—often invisibly—by the compensation systems through which they are seeking redress. The capacity to recognize, formulate, and address compensation-related stress is thus a matter of clinical competence and professional responsibility.

The manual begins by tracing the historical and theoretical foundations of the compensation-and-health debate, moving from early clinical constructs such as "accident neurosis" and "compensation neurosis" toward contemporary models grounded in stress research, organizational and procedural justice, and trauma theory. It then presents the conceptual models and psychological mechanisms through which compensation-related stress may exert its effects. A subsequent integrative review of empirical findings across studies examines the strength, direction, and consistency of the evidence, including methodological issues that complicate interpretation. The manual next explores psychological pathways and stress responses, mental health outcomes across the severity spectrum, and system-level and contextual influences on claimant well-being. It concludes with detailed clinical implications for psychologists, an examination of future research directions, and a synthesis of what the field currently knows and does not know.

Throughout, the intent is to move beyond simple summary. Each empirical finding is situated within its theoretical context, subjected to critical appraisal, and translated into implications for clinical formulation and intervention. The material is intended not as a set of prescriptions but as a framework for reflective, informed practice with a population whose suffering is compounded by systems that were designed to relieve it.

---

2. HISTORICAL AND THEORETICAL FOUNDATIONS

2.1 From Compensation Neurosis to Contemporary Stress Frameworks

The clinical observation that individuals pursuing compensation for injuries appear to recover more slowly, less completely, and with more persistent psychological complaints than non-claimants has a long history in medicine and psychiatry. Early twentieth-century clinicians introduced constructs such as "accident neurosis," "traumatic neurosis," and "compensation neurosis" to describe what were perceived to be prolonged symptomatic presentations among plaintiffs in personal injury and workers' compensation matters (Elbers et al., 2013). These constructs, though clinically influential for decades, were freighted with skepticism about the authenticity of claimant symptoms and often implied a degree of conscious or unconscious symptom exaggeration in pursuit of financial reward. The underlying assumption—that the presence of a claim was itself a probable explanation for prolonged illness—was seldom subjected to rigorous empirical scrutiny.

The dominant explanatory concept during this era was that of "secondary gain," a psychoanalytically rooted construct positing that ongoing illness offered unconscious benefits—financial, interpersonal, or intrapsychic—that reinforced symptomatic presentations. Applied to compensation seeking, secondary gain implied that the promise of monetary settlement functioned as a reinforcer of illness behavior, delaying recovery until settlement was achieved (Elbers et al., 2013). This framework had significant clinical and legal consequences. It fostered suspicion of claimants among treating clinicians, encouraged defense-oriented forensic evaluations to focus on malingering and symptom exaggeration, and justified the belief among some legal practitioners that claim resolution would in itself produce clinical improvement. This latter belief was captured in the folk clinical concept of the "greenback poultice"—the notion that a check from an insurer would prove curative (Strasburger, 1999).

The empirical evidence for a pure secondary gain model has never been strong. Longitudinal follow-up studies of individuals whose claims have settled have yielded mixed findings, with some showing improvement, others showing no change, and still others documenting continued or worsening symptoms (Elbers et al., 2013). More fundamentally, the secondary gain model rests on an inference about motivation that is difficult to test and easy to invoke as a rhetorical device. It also fails to account for the substantial mental health burden observed in claimants at the earliest measurable points post-injury, before financial incentives could plausibly have exerted an effect on symptom expression.

Beginning in the late twentieth century and accelerating through the first two decades of the twenty-first, an alternative framework has emerged. Rather than treating the compensation

process as an incentive structure that pulls claimants toward illness, this framework treats the process itself as a source of stress that pushes claimants into worsened functional and psychological states. In this reformulation, the compensation experience is a chronic psychosocial stressor characterized by adversarialism, uncertainty, repeated exposure to trauma-relevant material, procedural opacity, and asymmetric power relations. This view is supported by qualitative research documenting claimant distress (Grant et al., 2014), by quantitative studies linking specific claim experiences to poorer health (Grant et al., 2014; O'Donnell et al., 2015), and by broader work in occupational health demonstrating relationships between organizational injustice and physical and mental illness (Grant et al., 2014).

2.2 The Concept of Secondary Victimization

Complementing the reconceptualization of compensation as a stressor, the construct of "secondary victimization" has been increasingly deployed. Originating in the study of crime victims and disaster survivors, secondary victimization refers to distress that arises not from the primary traumatic event but from subsequent interactions with the systems ostensibly designed to assist the victim. Elbers and colleagues (2013) explicitly frame the compensation process as a potential source of secondary victimization, noting that repeated medical assessments, delayed benefit payments, adversarial encounters with insurers, and the sustained requirement to prove the reality and severity of one's injuries can produce renewed distress that layers upon the original injury.

The secondary victimization framework offers several advantages over earlier constructs. First, it is agnostic about claimant motivation, focusing instead on the objective and subjective features of the compensation environment. Second, it draws on well-developed literatures in stress research, organizational justice, and trauma studies. Third, it generates clear, testable hypotheses regarding which features of compensation systems are likely to be harmful and which reforms might reduce that harm.

2.3 Litigation as Psychological Process

The scholarly literature on the psychological effects of civil litigation more broadly, though often developed in relative isolation from the compensation literature, converges on remarkably similar themes. Strasburger (1999), in an influential clinical paper, articulated the

concept of the "litigant-patient"—the individual whose ongoing engagement with civil litigation shapes the process, content, and outcome of psychotherapy. Building on earlier work by Gutheil and colleagues, Strasburger introduced the term "critogenic harm" to describe emotional injury arising specifically from the legal process itself, in parallel with the term "iatrogenic harm" for injuries produced by medical treatment.

Strasburger (1999) emphasized that litigation, by its adversarial nature, thwarts normative psychological defenses—particularly avoidance—that individuals with trauma-related symptoms use to manage distressing material. Depositions, interrogatories, medical examinations, and courtroom testimony require the litigant to repeatedly confront and describe the very events they may be attempting to psychologically integrate or escape. In this analysis, litigation is not merely stressful in a general sense but is specifically anti-therapeutic for individuals whose clinical presentations depend on protective distance from traumatic content.

Halleck, cited within Strasburger's (1999) analysis, extended this line of reasoning with a negative-reinforcement model. In this model, the litigant faces implicit and explicit challenges to the authenticity of their symptoms. To preserve self-esteem, avoid being perceived as a malingerer, and justify the pursuit of compensation, the litigant may unconsciously become "more symptomatic." This process is understood not as fraudulent but as a psychological adaptation to the demands of an adversarial system that requires the claimant to continually demonstrate injury.

2.4 Organizational and Procedural Justice

A further theoretical strand grounding contemporary work is the literature on organizational and procedural justice. Grant and colleagues (2014) drew directly on this literature in developing measures of claim-related stress. Procedural justice research has demonstrated across multiple domains that individuals' evaluations of interactions with authorities and institutions are shaped less by the substantive outcome than by the perceived fairness of the process. Perceptions of being heard, treated with respect and dignity, and dealt with fairly have been consistently linked to satisfaction, trust, and, in occupational studies, physical and mental health outcomes.

When applied to compensation schemes, procedural justice theory generates specific predictions: claimants who perceive the process as fair, transparent, and respectful should have better psychological outcomes than those who perceive it as arbitrary, opaque, or degrading, independent of the eventual monetary outcome. The empirical findings reviewed in this manual are broadly consistent with these predictions and suggest that compensation-related stress is not a monolithic construct but is composed of identifiable procedural, interpersonal, and informational dimensions.

2.5 Diminished Resources and Stress-Vulnerability Frameworks

Finally, the diminished resources model of adjustment to stress, as invoked by O'Donnell and colleagues (2015), provides a useful framework for understanding why psychiatric symptoms in the acute post-injury period may amplify the perceived stressfulness of subsequent compensation processes. The model posits that an individual's capacity to manage ongoing stressors depends on the resources—cognitive, emotional, social, and material—that they can mobilize. Individuals with high levels of posttraumatic stress and depression have depleted resources: their attention is captured by intrusive symptoms, their concentration is impaired, their motivation is diminished, their social networks may be strained, and their capacity for effortful problem-solving is reduced. Faced with the demands of a compensation claim—paperwork, deadlines, medical examinations, communications with case managers—individuals with fewer resources experience the process as more taxing and more stressful, which in turn contributes to further functional impairment.

Together, these theoretical frameworks—secondary gain (largely superseded), secondary victimization, critogenic harm, procedural justice, and diminished resources—form the conceptual scaffolding for understanding the psychological consequences of compensation and litigation. They will be drawn upon throughout the sections that follow.

---

3. CONCEPTUAL MODELS AND MECHANISMS

3.1 A Bidirectional Model of Mental Health and Compensation Stress

The most sophisticated contemporary account of compensation-related psychological harm posits a bidirectional and temporally sequenced relationship between mental health status, compensation-related stress, and long-term disability. The model, elaborated most clearly in the longitudinal analyses of O'Donnell et al. (2015) and Grant et al. (2014), can be summarized as follows.

Following injury, individuals develop varying levels of acute psychological distress. Some develop clinically significant posttraumatic stress disorder, major depression, or anxiety disorders; others develop subthreshold but functionally meaningful symptoms. These acute symptoms exert two effects. First, they directly influence long-term functional outcomes through their impact on rehabilitation adherence, return to work, social engagement, and overall coping capacity. Second, and more novelly, they influence the individual's subsequent experience of the compensation process. Individuals with more severe acute symptoms are more likely to perceive the process as stressful, because their symptoms diminish the cognitive, emotional, and social resources needed to navigate a complex adversarial system.

Compensation-related stress, in turn, exerts its own independent effect on long-term disability, above and beyond the influence of the original acute symptoms. This effect operates through multiple pathways: prolonged sympathetic arousal and stress physiology, sustained negative affect, disruption of engagement in adaptive activities such as work and social participation, and reinforcement of illness behavior through repeated medical examinations and adversarial encounters.

The model is thus not one in which compensation stress "causes" mental illness in previously well individuals, nor one in which pre-existing mental illness "causes" claimants to falsely perceive the process as stressful. Rather, it is a model of mutual amplification: acute post-injury psychopathology heightens perceived compensation stress, and compensation stress heightens long-term disability, with each element contributing independently and interactively to the eventual outcome.

Figure 1, as conceptually described in Grant et al. (2014), depicts the determinants of long-term health outcomes following injury as a directed graph in which claimant preinjury characteristics, injury characteristics, and psychological response to injury each feed into both the experience of the claims process and directly into long-term health status. The claims experience, in turn, exerts its own effect on long-term health status. This model, when combined with the temporal sequencing evident in O'Donnell et al.'s (2015) structural

equation model, provides a rigorous framework for empirical investigation.

3.2 The Mechanisms of Compensation-Related Stress

Several specific mechanisms have been proposed and, in varying degrees, empirically supported for how compensation processes generate stress.

The first mechanism is procedural opacity and informational asymmetry. Grant et al. (2014) found that the single most commonly identified stressor was "understanding what you needed to do for your claim," with 33.9% of claimants rating this as highly stressful. Population-level studies of the experience of legal problems, cited in Grant et al. (2014), have documented that community members often have limited knowledge of their legal rights and the steps needed to pursue claims. This asymmetry between the sophisticated institutional actors (insurers, lawyers, medical assessors) and the individual claimant is a source of chronic uncertainty and helplessness.

The second mechanism is temporal prolongation. The mean time to claim resolution in many jurisdictions extends over years. Grant et al. (2014) found that 30.4% of claimants rated the amount of time taken to deal with their claim as highly stressful. This prolonged uncertainty holds the claimant's life in a state of suspended animation, preventing psychological closure and continuous re-activation of injury-related material. Strasburger (1999) observed that this can be likened to "watching an automobile accident in slow motion."

The third mechanism is repeated exposure and thwarted avoidance. Medical examinations are a required feature of the compensation process, used to establish the reality, severity, and stability of injuries and to calculate benefits. Grant et al. (2014) found that 26.9% of claimants rated the number of medical assessments as highly stressful. For individuals with PTSD or trauma-related depression, each such assessment requires renewed engagement with the traumatic event and its sequelae. This repeated confrontation, as Pittman and colleagues noted (cited in Elbers et al., 2013), thwarts the normal avoidance defenses that individuals with PTSD deploy, resulting in resurgent intrusive symptoms, hyperarousal, and distress.

The fourth mechanism is procedural injustice and adversarial confrontation. Claimants who feel they are not being heard, are treated without respect, or are subjected to unfair processes report substantial stress. Grant et al. (2014) documented that 22.1% of claimants rated "getting the compensation organization to listen to what you had to say" as highly stressful,

18.3% rated the level of respect and dignity with which they were treated, and 24.8% rated the fairness of the process. These experiences map directly onto the procedural justice literature, which has demonstrated in occupational and healthcare settings that perceived injustice is associated with increased risk of depression, anxiety, and physical illness.

The fifth mechanism, at the interpersonal level, concerns the erosion of social support. Strasburger (1999) noted that litigants often experience the "burning out" of family members, friends, and even treating professionals who tire of hearing about the case, cannot tolerate the litigant's preoccupations, or become suspicious of the authenticity of ongoing complaints. The result is progressive social isolation at exactly the point at which social support is most needed. Grant et al. (2014) documented negative attitudes from family, friends, colleagues, and healthcare professionals as identifiable, if less common, stressors.

The sixth mechanism involves loss of autonomy and control. Both plaintiffs and defendants in civil matters commonly experience the litigation process as a fundamental disruption of their sense of personal agency (Strasburger, 1999). The claimant must defer to the judgment of legal counsel, submit to the timetables of the insurer and court, and accept the intrusion of interrogatories and depositions into private life. For individuals whose original injury involved a loss of control—such as being the passive victim of a motor vehicle accident, workplace incident, or assault—these features of the litigation environment may resonate with and reactivate the original trauma.

3.3 The Diminished Resources Pathway

The diminished resources model, invoked by O'Donnell et al. (2015), provides an integrative account of how these various stress mechanisms interact with the claimant's pre-existing psychological state. On this view, an individual who emerges from injury with high levels of PTSD, depressive, or anxiety symptomatology has fewer resources to allocate to the demands of the compensation process. Concentration difficulties make paperwork onerous; intrusive memories make medical examinations acutely distressing; irritability heightens the sense of being disrespected; anhedonia and hopelessness diminish motivation to engage; social withdrawal cuts off potential sources of support. The same objective process, encountered by a psychologically depleted claimant, is more stressful than it would be for a claimant with intact coping resources.

The diminished resources model is important because it reframes the observation that psychiatric symptoms predict compensation stress not as evidence that claimants exaggerate or misperceive their circumstances but as evidence that their capacity to absorb the objective stressors of the system is compromised. This reframe has substantial clinical implications, discussed later in this manual.

3.4 Critogenic Harm and the Anti-Therapeutic Frame

Strasburger (1999) offered the concept of critogenic harm as a way of naming and delineating the specific injuries produced by legal processes. This concept invites clinicians to consider that certain elements of the legal environment are actively anti-therapeutic. Where clinical care seeks to promote integration, self-efficacy, safety, and privacy, litigation may promote fragmentation, external attribution, threat, and public exposure. Where psychotherapy encourages reduction of illness behavior in favor of functional engagement, litigation may implicitly reinforce illness behavior as a demonstration of injury.

This framing raises the possibility that some of what has traditionally been attributed to secondary gain—the persistence or worsening of symptoms during litigation—may be better understood as critogenic in origin: a response to a process that structurally impedes recovery. Halleck's negative-reinforcement model, described earlier, is a specific instance of this broader phenomenon.

3.5 A Note on Selection and Reverse Causality

Any conceptual model must contend with the possibility that observed associations between compensation and health outcomes reflect selection effects rather than causal effects of the compensation process. Individuals who elect to pursue compensation may differ systematically from those who do not: they may have more severe injuries, more distressing circumstances, less resilient personalities, higher pre-injury psychopathology, or greater experiences of blame and injustice. Elbers et al. (2013) found in their meta-analysis that approximately three-quarters of the observed mental health difference between claimants and non-claimants was already present at baseline, suggesting substantial selection effects.

However, selection does not preclude a causal contribution of the compensation process itself. Elbers et al. (2013) also demonstrated that mental health improvement between

baseline and follow-up was significantly less in the compensation group than in the non-compensation group, indicating an ongoing effect of the process net of baseline differences. Grant et al. (2014) and O'Donnell et al. (2015) further strengthened the causal case by demonstrating relationships between specific compensation-related stressors and outcomes within a sample of claimants, thereby avoiding the selection problems inherent in claimant-versus-non-claimant comparisons.

The most defensible current position, articulated in various forms across the reviewed literature, is that observed compensation-health associations reflect a mixture of selection effects, direct causal effects of the compensation process, and effects of pre-existing and injury-related characteristics that shape both the individual's psychological response to injury and their experience of the compensation system.

---

4. EMPIRICAL FINDINGS ACROSS STUDIES

4.1 The Longitudinal Landscape

The core empirical evidence base for the arguments developed in this manual derives from several complementary lines of research: (a) large prospective cohort studies of injury survivors that follow participants over multiple years and measure both psychological status and compensation experience; (b) meta-analyses of prospective cohort studies comparing claimants and non-claimants; and (c) qualitative and clinical-scholarly work characterizing the phenomenology of the litigant-patient.

The Australian Injury Vulnerability Study (IVS), which forms the empirical backbone of both O'Donnell et al. (2015) and Grant et al. (2014), is a multi-site, longitudinal cohort study of injured patients admitted to four Level 1 trauma services in Australia between April 2004 and February 2006. Participants were adults aged 16–70, English-proficient, admitted for at least 24 hours, and excluded if they had moderate or severe traumatic brain injury, were suicidal, or were psychotic. A total of 1,048 patients completed the baseline assessment, 904 the 3-month assessment, and 616 the 6-year follow-up. Among 6-year participants, 332 who had engaged in a compensation process related to their original injury constituted the analytic sample for the studies under review.

The IVS is notable for several methodological features that address common criticisms of the compensation-and-health literature: random selection stratified by length of hospital stay to remove selection bias toward longer stays, use of validated health outcome measures including the WHODAS II and CAPS, structured psychiatric diagnostic interviews using the MINI, and follow-up extending well beyond the two-year threshold at which most compensation-related processes remain unresolved.

4.2 Baseline Differences Between Claimants and Non-Claimants

Elbers et al. (2013) conducted the first meta-analysis specifically examining the effect of compensation processes on mental health, synthesizing ten prospective cohort studies with a total of 3,936 participants. Studies included victims of motor vehicle accidents, workplace accidents, and various other injuries, and were drawn from Australia, the United States, and the United Kingdom. Compensation systems represented included no-fault schemes, third-party liability schemes, workers' compensation, and litigation-based systems.

The first major finding of Elbers et al. (2013) was that individuals who ultimately pursued compensation had higher mental health complaints at baseline than those who did not, with a standardized mean difference of –0.38 (95% CI –0.66 to –0.10, p = .01). Heterogeneity was high, but subgroup analyses removing studies that measured baseline pre-injury (i.e., retrospective) revealed a homogeneous and larger effect of –0.54. The compensation group scored higher on depression (SMD = –0.42) and PTSD symptoms (SMD = –0.47), with a smaller and non-significant elevation in anxiety (SMD = –0.22).

The clinical relevance of this baseline difference, expressed on a 0–10 scale, was approximately 7.8%. While below the 10% threshold typically considered clinically significant, this difference is substantial and consequential for interpreting subsequent findings. Elbers et al. (2013) noted that this baseline difference accounts for approximately three-quarters of the eventual observed mental health difference at follow-up (10.1%), meaning that the additional effect attributable to the compensation process itself, over and above the baseline difference, was approximately 2.3%.

Several explanations for the baseline difference have been proposed. First, selection into the compensation group may reflect greater injury severity, more distressing circumstances (e.g., higher rates of motor vehicle accidents versus falls), or more experiences of fault, blame, and

anger. Second, individuals may develop a "compensation mindset" between injury and baseline assessment, portraying themselves as more distressed once they have decided to pursue a claim. Third, claimants may experience more anger and injustice about the original accident, which may itself contribute to elevated distress. The available evidence does not definitively adjudicate between these explanations, and it is likely that they operate in combination.

4.3 Change Over Time and the Effect of Compensation Process

The second major finding of the Elbers et al. (2013) meta-analysis was that mental health improved less between baseline and follow-up in the compensation group than in the non-compensation group, with a standardized mean difference of −0.35 (95% CI −0.70 to −0.01, p = .05). Heterogeneity was again high, and subgroup analyses by time point (6, 12, and 24 months) did not consistently reduce it. The clinical relevance of the differential change was approximately 2.3%, below the conventional threshold of clinical importance.

The GRADE quality of evidence assessment applied by Elbers et al. (2013) rated the overall quality of evidence as very low, primarily due to limitations in study design (observational, unclear exposure assessment, non-blinded outcome assessment, high attrition), heterogeneity across compensation systems and outcome measures, imprecision of results, and possible publication bias. This assessment is important context for interpreting the findings: the direction of the effect is consistent with a compensation stress mechanism, but the magnitude and specificity of the effect remain uncertain.

4.4 The Nature and Prevalence of Compensation-Related Stress

Grant et al. (2014), drawing on the IVS cohort at six-year follow-up, provided the most detailed empirical characterization to date of the specific aspects of the compensation experience that claimants find stressful. Using the Claim Experience Survey, developed drawing on the organizational and procedural justice literatures and prior qualitative work, Grant et al. asked claimants to rate the stressfulness of nine specific aspects of their compensation experience.

The results, summarized in Table 1, revealed that a substantial proportion of claimants experienced high levels of stress from multiple aspects of the process.

Table 1. Prevalence and Mean Intensity of Compensation-Related Stressors (adapted from Grant et al., 2014)

Stressor	% Reporting High Stress	Mean Intensity (1–5)
Understanding claim requirements	33.9%	3.9
Time taken to deal with claim	30.4%	4.1
Number of medical assessments	26.9%	3.9
Amount of compensation received	26.1%	4.0
Fairness of process	24.8%	4.0
Being listened to	22.1%	4.3
Respect and dignity	18.3%	3.8
Negative attitudes from health professionals	7.9%	3.7
Negative attitudes from family/friends	6.9%	4.0

Confirmatory factor analysis indicated that six of these stressor items (excluding the fairness item, which was highly collinear with others, and the two least-endorsed items) grouped well into a single factor with strong internal consistency (Cronbach's $\alpha = 0.87$), suggesting an underlying general dimension of compensation-related stress. This supports the use of an aggregate stress measure while also permitting analysis of specific stressor domains.

Notably, 37% of claimants in the O'Donnell et al. (2015) analysis reported no compensation-related stress at all (scoring 0 on all seven items in their variant of the measure). Compensation-related stress is thus not a universal feature of the claims experience; rather, it is a substantial minority experience whose distribution requires explanation.

4.5 The Relationship Between Compensation Stress and Long-Term Outcomes

Grant et al. (2014) tested the relationship between compensation-related stress and 6-year health outcomes across four measures: disability (WHODAS II), quality of life (WHOQOL overall item), anxiety (HADS), and depression (HADS). Multivariable regression models adjusted for age, income, injury severity, hospitalization duration, sex, preinjury psychiatric history, compensation scheme, and baseline health status.

The findings were striking. Claimants who reported high stress from understanding claim requirements had, six years later, significantly higher disability ($\beta = 6.06$, 95% CI 4.27 to 7.87), lower quality of life ($\beta = -0.53$, 95% CI −0.76 to −0.29), and higher anxiety ($\beta = 2.19$) and depression ($\beta = 2.26$). Similar patterns were observed for each of the six stressors, with all 24 stressor–outcome combinations showing significant negative associations in the primary models.

To address the possibility that these associations reflected claimants' pre-existing vulnerability to experiencing stress, Grant et al. (2014) developed propensity scores summarizing each claimant's likelihood of reporting stress from each stressor, based on demographic, preinjury, injury, and 3-month psychological variables. Adjustment for the propensity score attenuated the associations, and in seven of the 24 stressor–outcome combinations the association became non-significant. However, 17 combinations remained statistically significant after propensity score adjustment, indicating that compensation-related stress remained associated with worse long-term outcomes over and above claimants' pre-existing vulnerability to stress.

The magnitude of these associations is clinically meaningful. Marginal effects analyses indicated that the highest-stress claimants (90th percentile of aggregate stress) had estimated WHODAS scores 6.94 points higher than no- or low-stress claimants (10th percentile), placing them in the highest decile of disability scores in the general Australian population.

4.6 Mediation Through Compensation Stress: The O'Donnell Model

O'Donnell et al. (2015) extended the Grant et al. (2014) findings by testing a specific temporal mediation model using structural equation modeling. Their model specified that 3-month psychiatric symptoms (PTSD, depression, and anxiety) would predict 6-year disability both directly and indirectly through compensation-related stress at 6 years.

The results supported the mediational model. A significant direct relationship was observed between compensation-related stress and 72-month disability ($\beta = 0.35$, $p < .001$). Three-month PTSD symptoms were significantly related to compensation stress ($\beta = 0.29$, $p < .001$) and 72-month disability, both directly ($\beta = 0.31$, $p < .001$) and indirectly through compensation stress ($\beta = 0.10$, $p = .001$). Three-month depression symptoms had an even stronger relationship with compensation stress ($\beta = 0.39$, $p < .001$) and were related to 72-month disability indirectly through compensation stress ($\beta = 0.14$, $p < .001$), although the direct relationship of 3-month depression to 72-month disability was not significant.

Three-month anxiety symptoms, in contrast, had no significant relationship with compensation stress or with 72-month disability. This differential pattern is theoretically important: it suggests that PTSD and depression, but not anxiety per se, are the acute psychological states most consequential for the perceived stressfulness of the compensation process. This may reflect the specific ways in which PTSD (with its intrusion, avoidance, and hyperarousal) and depression (with its concentration deficits, hopelessness, and social withdrawal) impair the resources needed to navigate an adversarial system. Anxiety in isolation, without the specific features of trauma or depression, may not exert the same effect.

The model fit indices were strong (CFI = .95, TLI = .94, RMSEA = .06, SRMR = .06), indicating a well-fitting model. Importantly, injury characteristics themselves contributed to 72-month disability via a significant direct pathway ($\beta = 0.22$, $p = .001$), confirming that compensation-related stress operates alongside, not in place of, the effects of physical injury severity.

4.7 Convergences and Divergences Across Studies

Across these diverse studies, several convergent findings emerge. First, claimants have worse mental health at baseline than non-claimants, with much of this difference likely reflecting selection effects. Second, claimants improve less over time than non-claimants, with the additional decrement attributable to the compensation process being modest in absolute terms but consistent in direction. Third, within claimants, the perceived stressfulness of the compensation experience is significantly associated with worse long-term outcomes across disability, quality of life, and mental health domains. Fourth, this within-claimant effect is partially but not fully accounted for by pre-existing vulnerability, indicating an additional contribution of the compensation process itself. Fifth, acute psychiatric

symptoms—particularly PTSD and depression—amplify the perceived stressfulness of the compensation process, creating an indirect pathway from acute distress to long-term disability.

Divergences and areas of ongoing uncertainty include the following. The magnitude of the causal effect of the compensation process, distinct from selection, remains contested (Elbers et al., 2013). Whether specific compensation scheme designs (no-fault vs. third-party liability) produce different psychological outcomes is under-studied. The role of specific claim milestones—claim initiation, dispute, settlement—in shaping psychological trajectories is not well characterized. And the extent to which findings from Australian schemes generalize to other jurisdictions with different legal frameworks, benefit structures, and cultural contexts is uncertain.

---

5. PSYCHOLOGICAL PATHWAYS AND STRESS RESPONSES

5.1 Acute Stress and the Trajectory of Post-Injury Symptomatology

To understand the psychological pathways through which compensation processes may impede recovery, it is helpful to first situate compensation stress within the broader context of post-injury psychological trajectories. Following a serious injury requiring hospitalization, a substantial minority of survivors develop clinically significant psychiatric disorders. In the IVS sample described by O'Donnell et al. (2015), prevalence rates at three months post-injury among claimants included 12.6% for major depressive episode, 6.9% for PTSD, and 4.4% for panic disorder, along with elevated rates of social phobia and generalized anxiety disorder. These rates are consistent with broader literatures documenting substantial psychiatric morbidity following traumatic injury.

The trajectory of these acute symptoms varies considerably. Some individuals demonstrate resilient courses, with initial elevations remitting within weeks. Others show delayed onset, with symptoms emerging months after injury as physical recovery plateaus and life stressors accumulate. Still others follow chronic trajectories, with sustained or worsening symptoms over years. Compensation-related stress, in the model developed here, is one of the factors that shapes these trajectories, particularly among those with initially elevated symptoms.

5.2 The Amplification Pathway

The findings of O'Donnell et al. (2015) support what may be termed an amplification pathway, in which acute psychiatric symptoms and compensation-related stress mutually reinforce one another over time. Consider a hypothetical claimant who develops significant PTSD symptoms in the weeks following a motor vehicle collision. The individual experiences intrusive memories of the collision, avoids driving and situations reminiscent of the crash, and is hyperaroused, easily startled, and irritable. Concentration is impaired; sleep is disrupted; interpersonal functioning is strained.

This individual is then required to engage with a compensation scheme. The initial paperwork requires them to describe the accident in detail (activating intrusive memories), to attend medical examinations at specified times (which they may find difficult to organize given concentration impairments), and to submit to physical and psychological assessments (which involve extended discussion of the injury and its consequences, activating both intrusion and avoidance conflicts). The process extends over months and years, during which each contact from the insurer may re-activate distress. Delays are perceived as evidence of institutional indifference; requests for further examinations are perceived as attacks on the credibility of the injury.

The result, in the amplification model, is a mutually reinforcing cycle. PTSD symptoms make the compensation process more stressful. Compensation stress in turn perpetuates and may worsen PTSD symptoms through repeated activation and thwarted avoidance. Both contribute to functional disability. The cycle is often invisible to observers—including clinicians—who may attribute persistent symptoms either to the original injury or to secondary gain, missing the ongoing contribution of the compensation process.

5.3 The Diminished Resources Pathway

An alternative but complementary account, drawing on the diminished resources framework, emphasizes not amplification of symptoms but depletion of coping resources. In this account, acute psychiatric symptoms do not necessarily worsen during the compensation process; they simply consume resources that would otherwise be available for coping with the objective demands of that process. The individual with major depression may find the paperwork

overwhelming not because of any particular activation of depressive symptoms but because depression has depleted the executive resources needed for complex administrative tasks. The individual with PTSD may find medical examinations onerous not because they activate specific intrusive symptoms but because hyperarousal has depleted the emotional reserve needed to tolerate any additional stress.

The clinical implications of these two accounts differ. The amplification account suggests interventions that target the specific interactions between symptoms and process (e.g., preparation for medical examinations that includes grounding and exposure techniques). The diminished resources account suggests interventions that support general coping capacity (e.g., psychoeducation, stress management, mobilization of social support). In practice, both are likely operative, and comprehensive intervention should address both.

5.4 Stress Physiology and Chronic Activation

The mental and physical health effects of chronic stress are grounded in well-established stress physiology. Prolonged activation of the hypothalamic-pituitary-adrenal axis, sustained sympathetic arousal, and chronic elevation of inflammatory markers are associated with increased risk of cardiovascular disease, metabolic dysfunction, immune dysregulation, and depression. The compensation process, particularly when experienced as unfair, opaque, and prolonged, constitutes exactly the kind of chronic stressor associated with these adverse physiological trajectories.

O'Donnell et al. (2015) explicitly linked their findings to the broader literature on stress and health, noting that the observed relationship between self-reported compensation-related stress and later disability extends previous findings on stress and health to the specific context of the claims process. The pathways—both psychological and physiological—by which chronic stress translates into functional disability are increasingly well characterized and provide a coherent biological substrate for the observed associations.

5.5 Procedural Justice, Injustice, and Emotional Response

The procedural justice framework highlights specific emotional responses that arise when individuals perceive processes as unfair, disrespectful, or unresponsive. These emotions—anger, humiliation, resentment, and a sense of betrayal—are themselves powerful

stressors with well-documented health effects. When claimants experience the compensation process as procedurally unjust, they are not simply dissatisfied; they are experiencing emotions that in themselves carry health consequences.

Strasburger (1999) documented this phenomenon in the litigation context, noting that plaintiffs frequently experience the process as attacking their integrity and honesty. Cross-examination, in particular, can feel like a personal assault, and the sense of being disbelieved or minimized can compound the original injury. The observation that being listened to had the highest mean stress intensity among Grant et al.'s (2014) stressors—despite being reported by only 22.1% of claimants—speaks to the depth of distress that procedural voice failures produce among those who experience them.

5.6 Trauma Reactivation and the Anti-Avoidance Structure

For claimants with PTSD or trauma-related presentations, the compensation process has a specific and potent anti-therapeutic feature: it structurally requires the claimant to repeatedly and formally describe the traumatic event. This requirement runs directly counter to the avoidance dimension of PTSD, in which the individual protects themselves from distressing material through cognitive, behavioral, and interpersonal strategies. When the compensation process forces engagement with the very material that avoidance is designed to keep at bay, the result is a resurgence of intrusive symptoms and hyperarousal.

Strasburger (1999) noted that this feature of the litigation process has particular implications for the timing of clinical intervention. Standard trauma-focused treatments, such as prolonged exposure therapy, work by systematic and controlled engagement with traumatic material within a therapeutic frame. The compensation process, in contrast, involves uncontrolled engagement within an adversarial frame, and may make it more difficult for clinicians to establish the safety and predictability required for effective trauma-focused treatment. Timing of trauma-focused work relative to the compensation timeline is thus a matter requiring careful clinical judgment.

5.7 Identity, Illness Behavior, and the Sick Role

Halleck's (as cited in Strasburger, 1999) negative-reinforcement model draws attention to a subtle but consequential process in which the claimant's identity becomes bound up with the

demonstration of injury. To pursue compensation is to make a public claim that one has been injured and is entitled to redress. When that claim is challenged—as it inevitably is in an adversarial system—the claimant is placed in a position of having to defend not only the reality of the injury but their own honesty and integrity.

One psychological adaptation to this position is to become "more symptomatic," not fraudulently but in the sense of increasing attention to symptoms, reduced tolerance for functional demands, and adoption of illness behaviors that visibly demonstrate the injury. Over time, this adaptation may consolidate into what is sometimes called the sick role: an identity organized around illness and disability rather than function and engagement. Once consolidated, the sick role is difficult to modify, and it may persist beyond the resolution of the underlying injury and the compensation claim.

Strasburger (1999) cautioned that prognostic testimony offered by therapists in legal proceedings may itself contribute to sick role consolidation. If a patient hears their therapist testify to a pessimistic prognosis, they may internalize that prognosis and adjust their behavior accordingly. Conversely, an optimistic prognosis may create pressure to conceal ongoing symptoms. Either way, the intersection of clinical testimony and clinical trajectory constitutes an underappreciated site of iatrogenic and critogenic influence.

---

6. MENTAL HEALTH OUTCOMES AND SEVERITY SPECTRUM

6.1 The Spectrum of Post-Injury Psychopathology

The mental health outcomes associated with injury and its compensation-related sequelae span a broad spectrum, from subclinical distress to severe and chronic psychiatric disorders. Understanding this spectrum is essential for psychologists working with injured populations, as intervention needs and prognostic considerations vary substantially across it.

At one end of the spectrum, some individuals experience transient distress that resolves without formal intervention. Even in the context of significant injury and prolonged compensation processes, resilience is common. In the O'Donnell et al. (2015) sample, 37% of claimants reported no compensation-related stress at all, suggesting that a substantial

proportion navigate the process without perceiving it as psychologically burdensome. These individuals may nonetheless experience physical recovery challenges and require rehabilitation support, but they do not necessarily present with psychological pathology.

At the other end of the spectrum are individuals with severe, chronic, and disabling psychiatric conditions. In the IVS sample, six-year follow-up documented WHODAS scores among the highest-stress claimants that placed them in the top decile of disability in the general Australian population. These individuals typically present with comorbid PTSD and depression, often complicated by chronic pain, substance use, and social and occupational impairment. Their prognosis, particularly if compensation-related stress remains active, is guarded.

Between these poles lie the majority of claimants, who experience varying combinations of depressive, anxious, and posttraumatic symptomatology of moderate severity, often waxing and waning over months and years. These individuals may not meet full diagnostic criteria for any particular disorder at any single assessment but may accrue substantial cumulative burden across time.

6.2 PTSD and Trauma-Related Presentations

PTSD is a particularly consequential outcome in the compensation context, both because of its high prevalence following injury and because of the specific ways in which PTSD interacts with the demands of the compensation process. As documented above, O'Donnell et al. (2015) found that acute PTSD symptoms predicted compensation-related stress at six years, which in turn predicted long-term disability. The direct effect of acute PTSD on long-term disability was also significant, and the indirect effect through compensation stress added to this direct effect.

Clinically, the trauma-related presentations most commonly encountered in claimant populations include full PTSD with the classic constellation of intrusion, avoidance, negative alterations in cognition and mood, and hyperarousal; subthreshold PTSD, in which some but not all diagnostic criteria are met but functional impairment is significant; and complex trauma presentations, particularly in individuals with pre-existing trauma histories, in which the recent injury interacts with prior traumatic material.

The compensation process may exacerbate any of these presentations, but it may also, paradoxically, provide a structured focus that some individuals experience as containing and meaningful. Grant et al. (2014), citing prior work, noted that the legal process can be empowering for some claimants—particularly in cases involving harassment, assault, or intentional injury—by providing an arena in which the victim can hold the offender accountable. This dimension is under-emphasized in the literature but clinically important: for some individuals, the compensation process is not simply a stressor but also a source of agency and meaning.

6.3 Depression

Depression emerges as perhaps the most consequential mental health condition for compensation-related outcomes in the O'Donnell et al. (2015) analyses. Three-month depression had the strongest relationship with compensation-related stress ($\beta = 0.39$), stronger even than the relationship of PTSD with compensation stress. The indirect effect of depression on long-term disability through compensation stress was substantial ($\beta = 0.14$).

Several features of depression may make it particularly consequential in the compensation context. Depressive concentration and memory difficulties impair the claimant's capacity to manage complex paperwork and communications. Hopelessness may lead to premature abandonment of claims or, alternatively, to fatalistic engagement. Anhedonia diminishes motivation for the rehabilitation activities that would demonstrate functional recovery. Depressive cognitions—of worthlessness, guilt, and inadequacy—may interact with the demands of the compensation system to produce a sense that one is not entitled to redress and does not deserve support. Social withdrawal cuts off the support that would otherwise buffer the stress of the process.

Depression is also notably responsive to intervention, both pharmacological and psychological. This creates a specific clinical opportunity: early identification and treatment of depression in the acute post-injury period may not only address the depressive symptoms themselves but may reduce the subsequent perceived stressfulness of the compensation process and, through that pathway, reduce long-term disability.

6.4 Anxiety Disorders

The pattern of findings for anxiety is more complex. In the O'Donnell et al. (2015) structural equation model, three-month anxiety symptoms had no significant relationship with compensation-related stress or with long-term disability. This finding, at first surprising, suggests that anxiety symptoms in the absence of the specific features of PTSD or depression may not exert the same amplifying effect on the compensation experience.

Several interpretations are possible. Anxiety may reflect a more diffuse response to the injury that dissipates as physical recovery proceeds, without the specific interactive features that link PTSD (through trauma reactivation) and depression (through resource depletion) to the compensation process. Alternatively, anxiety in this context may reflect an activated coping response that supports engagement with the compensation demands, in contrast to depression which impedes engagement.

Clinically, this differential pattern suggests that not all post-injury distress carries the same implications for long-term compensation-related outcomes. Careful diagnostic differentiation matters: an individual with anxiety symptoms alone may have a substantially different prognosis than one with PTSD or depression, even if the level of general distress appears similar on brief screening measures.

6.5 Comorbidity and Complexity

In practice, mental health presentations in claimant populations are frequently comorbid. PTSD and depression co-occur at high rates following injury, and both may be complicated by chronic pain, sleep disturbance, substance use, and interpersonal difficulties. The presence of comorbidity substantially complicates clinical formulation and treatment planning. It also has implications for the compensation context: comorbid presentations may be more difficult to characterize in medical-legal reports, more difficult to attribute causally to the injury, and more difficult to treat effectively during ongoing litigation.

6.6 Chronic Pain and the Body

Although not the focus of the reviewed literature, chronic pain is a frequent companion to the mental health presentations examined here, and its interaction with compensation processes has been extensively studied elsewhere. Meta-analyses of surgical and orthopedic outcomes cited by O'Donnell et al. (2015) and Elbers et al. (2013) consistently show worse outcomes

among compensation claimants. The mechanisms overlap substantially with those discussed above: chronic pain interacts with depression and PTSD to amplify distress and disability, and the compensation process may perpetuate pain through repeated medical examinations, adversarial encounters, and the ongoing requirement to demonstrate impairment.

6.7 Quality of Life and Functional Impairment

Beyond specific psychiatric diagnoses, the reviewed literature emphasizes broader outcomes of quality of life and functional disability. Grant et al. (2014) demonstrated that compensation-related stress was associated with significant reductions in overall quality of life as measured by the WHOQOL, and O'Donnell et al. (2015) documented substantial elevations in WHODAS disability scores. These outcomes are clinically important because they capture the lived experience of impairment across social, occupational, and personal domains, transcending the boundaries of specific diagnoses.

The magnitude of the functional impact deserves emphasis. The estimated WHODAS score difference between low-stress and high-stress claimants of nearly seven points, in a scale ranging from 0 to 48, represents substantial functional impairment. Placing high-stress claimants in the highest decile of disability in the general population indicates that the aggregate impact of compensation-related stress is not merely a matter of subjective distress but of concrete limitations in daily life.

---

7. SYSTEM-LEVEL AND CONTEXTUAL PSYCHOLOGICAL EFFECTS

7.1 Compensation Scheme Design and Its Psychological Implications

Compensation schemes vary substantially across jurisdictions in their design and operation, and these design features have measurable consequences for claimant experience and outcomes. The reviewed studies encompass a range of scheme types, including no-fault motor vehicle accident schemes, third-party liability schemes, workers' compensation schemes, and litigation-based systems. Although the meta-analytic evidence is not yet strong

enough to establish differential effects with confidence, several observations can be made.

Elbers et al. (2013) noted evidence, drawn from studies not included in their meta-analysis but discussed in their review, that no-fault systems may be associated with better health outcomes than third-party liability systems. The mechanism, if this association is causal, likely involves reduced adversarialism, faster resolution, and elimination of the requirement to establish fault and blame. No-fault schemes remove the need for claimants to prove that another party caused their injury, potentially reducing the anger, blame, and injustice that appear to characterize claimant experience in adversarial systems.

The implications of scheme design extend beyond the presence or absence of fault requirements. Schemes vary in their benefit structures (lump-sum vs. periodic payments; medical-only vs. income replacement), in the level of case management provided, in the transparency of decision-making, and in the availability of dispute resolution mechanisms. Each of these features may plausibly influence claimant psychological outcomes, but the empirical evidence is limited.

7.2 Case Management and Institutional Contact

Beyond the formal design of compensation schemes, the day-to-day interactions between claimants and case managers, insurers, and other institutional actors have substantial psychological impact. Grant et al. (2014) noted that "being heard" and "treated with respect and dignity" were highly stressful features for a substantial minority of claimants when they were perceived as lacking. This suggests that the interpersonal quality of case management may be as consequential as the formal features of the scheme.

O'Donnell et al. (2015) suggested that "simple strategies such as reflective listening by compensation agency case managers may assist in this process," drawing on evidence that reflective listening training in corporate settings improves outcomes. This suggests that relatively modest investments in the interpersonal skills of case managers could yield meaningful reductions in compensation-related stress.

7.3 Delay and Prolongation

The temporal dimension of the compensation process deserves specific attention. Delays in decision-making, prolonged uncertainty, and extended claim resolution timelines emerge across the reviewed literature as important sources of stress. Grant et al. (2014) found that 30.4% of claimants rated the amount of time taken to deal with their claim as highly stressful, second only to understanding requirements.

Delay operates as a stressor through multiple pathways. It prolongs uncertainty about outcomes, creating chronic anxiety. It suspends life planning, preventing the claimant from making decisions about employment, housing, and family. It signals institutional indifference, generating anger and frustration. And it extends the duration of exposure to all other stressors of the process. Reducing delays is therefore likely to produce broad benefits across the psychological outcomes of interest.

7.4 Medical Examinations and Assessment Burden

The requirement to undergo multiple medical examinations is a defining feature of most compensation schemes and, as documented, a substantial source of claimant stress. Each examination requires the claimant to describe their injury and its consequences, to submit to physical or psychological assessment, and to have their credibility implicitly evaluated. For claimants with PTSD, each examination reactivates traumatic material; for those with depression, each represents an additional demand on depleted resources.

Reducing the number of medical examinations while maintaining adequate assessment of claims is a specific system-level intervention with plausible psychological benefits. Coordination among assessors, sharing of records, and use of independent multi-purpose evaluations may reduce the total assessment burden without compromising the integrity of claim adjudication.

7.5 The Legal Professional Interface

The role of legal representation in shaping claimant experience deserves attention. Strasburger (1999) noted substantial variation among attorneys in their capacity to be emotionally supportive to clients. Some attorneys actively encourage counseling or psychotherapy for their clients during litigation, understanding that mental health support improves prognosis. Others withhold such referrals, believing that visible distress supports the

case. Some engage clients in genuine informed-consent discussions about the stresses of litigation before commencement; others do not.

This variation has implications not only for individual claimant outcomes but for the profession of psychology in its interactions with the legal system. Psychologists working with claimant populations frequently interact with legal representatives, whether directly through referrals or indirectly through documentation and testimony. Building constructive relationships with legal professionals, educating them about the psychological consequences of the litigation process, and advocating for practices that support rather than undermine claimant well-being are all appropriate professional activities.

7.6 Cultural and Contextual Factors

The literature reviewed here is drawn predominantly from Australian, American, British, and Western European contexts, and the compensation schemes involved reflect the legal traditions of those jurisdictions. The generalizability of findings to other cultural contexts is uncertain. Cultural variation in attitudes toward help-seeking, disability, financial redress, and institutional authority may all shape claimant experience in ways that the current literature does not adequately capture.

Additionally, within any given jurisdiction, cultural, linguistic, and socioeconomic factors likely shape claimant experience. Claimants with limited English proficiency may find the informational demands of the process particularly stressful; those with low socioeconomic status may face compounding financial pressures during prolonged claims; those from cultural backgrounds emphasizing collective rather than individual identity may experience the individualized adversarial process as alienating. These considerations, while not directly examined in the reviewed studies, are important for psychologists working with diverse claimant populations.

7.7 The Role of Public Discourse

Finally, the broader discourse about injury compensation—in media, political rhetoric, and public opinion—shapes the environment in which claimants pursue their claims. Discourses that emphasize fraudulent claims, malingering, and excessive litigation create a climate of suspicion that claimants may internalize and against which they must defend. Strasburger

(1999) noted that plaintiffs frequently feel embarrassment and humiliation about their claims, feelings that are reinforced by public discourse portraying claimants unfavorably.

Psychologists working with claimant populations may need to actively address the impact of this discourse on their patients, providing psychoeducation about the realities of the compensation process and normalizing help-seeking. At a professional level, contributing to public discourse in ways that accurately reflect the psychological realities of injury compensation is a legitimate advocacy activity.

---

8. CLINICAL IMPLICATIONS FOR PSYCHOLOGISTS

8.1 Screening and Early Identification

The empirical evidence reviewed here has clear implications for early identification of individuals at risk of poor long-term outcomes. In the acute post-injury period, screening for PTSD, depression, and anxiety symptoms is a well-established practice with strong evidence support. The findings of O'Donnell et al. (2015) add a specific rationale for such screening in claimant populations: acute PTSD and depression symptoms predict not only long-term psychological outcomes but also perceived compensation-related stress, which in turn predicts disability. Identifying at-risk individuals in the acute period thus opens a window for intervention that may reduce both direct and indirect pathways to poor outcomes.

Standard screening instruments including the Hospital Anxiety and Depression Scale (HADS) and brief PTSD screens can be integrated into routine post-injury care. Psychologists working in hospital-based, rehabilitation, and primary care settings should advocate for such screening and be prepared to conduct or supervise appropriate follow-up assessment.

8.2 Stepped-Care Early Intervention

O'Donnell et al. (2015) noted the promise of stepped-care early intervention models for post-injury mental health, referencing Zatzick and colleagues' work on stepped care for trauma survivors. In such models, universal screening identifies individuals at elevated risk;

those identified receive brief intervention; those who do not respond are stepped up to more intensive intervention. This approach efficiently allocates resources while ensuring that individuals with greater needs receive greater support.

One important feature of Zatzick and colleagues' model, noted by O'Donnell et al. (2015), is that engaging clients in empathic discussions about disability and financial compensation is a central component. This is consistent with the framework developed in this manual: addressing compensation-related concerns is not a peripheral or optional element of post-injury care but a core component with direct implications for outcomes.

Psychologists are well-positioned to develop, deliver, and supervise stepped-care interventions. The evidence base for brief cognitive-behavioral interventions in the acute post-injury period is developing, and psychologists can contribute both to clinical delivery and to the research needed to strengthen this evidence base.

8.3 Treatment Considerations for the Claimant Population

Psychologists providing treatment to individuals engaged in compensation processes should consider several specific issues.

First, the treatment should acknowledge and address the reality of the compensation experience. This does not mean that the therapy becomes about the litigation; rather, it means that the impact of the litigation on the patient's psychological state is recognized as legitimate clinical material. Strasburger (1999) noted that therapists must be attentive to when the patient uses the therapy hour to "plead their case" as a form of resistance to deeper clinical work; the balance between validation and interpretation requires careful judgment.

Second, timing of trauma-focused interventions requires special consideration. The core techniques of trauma-focused therapy—including detailed engagement with traumatic memory—overlap with the demands of the compensation process (medical examinations, testimony). Coordinating trauma-focused work with the timeline of the compensation process, and preparing the patient for the emotional demands of both, is a clinical task requiring both trauma expertise and awareness of the legal context.

Third, the pace of therapy may be slower than in non-litigating populations. Strasburger (1999) noted that "do not expect too much of the patient. The psychotherapy may be very

slow-going." This is consistent with the diminished resources framework: patients whose energies are consumed by the compensation process have less available for therapeutic work.

Fourth, the therapist should be alert to the risk that the compensation process may reinforce illness behavior, and should structure the therapy to promote functional engagement rather than symptom demonstration. This does not mean minimizing symptoms or expressing skepticism about the injury; rather, it means consistently orienting the therapy toward valued life activities and recovery of function.

8.4 Managing Transference and Countertransference

Strasburger (1999) provided rich clinical observations on the transference and countertransference phenomena that arise in treating litigant-patients. Transferences from attorneys, insurers, and forensic evaluators may be displaced into the therapeutic relationship. A cynical or exploitative attorney may generate mistrust that the patient enacts with the therapist; a supportive attorney may create idealization that the therapist inherits. Anger at the insurer may spill into anger at the therapist; disappointment with the legal system may generalize into disappointment with treatment.

Countertransferentially, psychologists may find themselves drawn into advocacy for the patient, potentially compromising therapeutic neutrality. The urge to become the patient's champion, particularly in cases where the patient has been genuinely wronged, is understandable but should be examined. Alternatively, therapists may find themselves suspicious of the patient's presentation, mirroring the skepticism of the adversarial system and undermining the therapeutic alliance. Awareness of these pulls, ideally supported by supervision or peer consultation, is an important professional practice.

Additionally, therapists should recognize the possibility of envy—of the patient's potential financial award, of their public platform for expressing grievance—as a countertransference element. This possibility, while uncomfortable, deserves acknowledgment.

8.5 Documentation Considerations

Psychologists working with litigant-patients face specific documentation challenges. Clinical records may be subject to subpoena and become part of the legal record. Strasburger (1999) advised discretion in documentation, particularly regarding conclusory statements about causation. Symptoms, diagnoses, and treatment can be recorded without making specific attribution to legal causation, which is a matter for forensic evaluation rather than clinical treatment.

Notes should not include material from the patient's attorney or reflect legal strategy. Statements such as documenting settlement negotiations would be inappropriate in a clinical record. The record should serve the clinical purpose of documenting the treatment, not the legal purpose of building or countering a case.

8.6 Boundaries with Forensic Roles

The distinction between therapeutic and forensic roles is a foundational principle of psychological practice. Strasburger (1999), building on earlier work with Gutheil and Brodsky, emphasized the "irreconcilable conflict" between the therapeutic role of the treating clinician and the forensic role of the expert witness. Serving simultaneously in both roles compromises both.

Psychologists treating litigant-patients should be prepared to explain and maintain this distinction, both to patients and to attorneys. Attorneys may pressure treating psychologists to serve as expert witnesses because the treating relationship provides access to detailed clinical material. This pressure should be resisted; if forensic evaluation is needed, it should be conducted by an independent evaluator.

When treating psychologists are deposed or called to testify as fact witnesses (as opposed to expert witnesses), the appropriate stance is honesty about the clinical facts within the limits of the treating role. Strasburger (1999) noted that "it is not the therapist who is on trial" and that being deposed, while stressful, is survivable.

Documenting for the patient after the therapist has testified—a "debriefing"—is often clinically indicated, particularly when the patient may have heard or read the testimony.

8.7 Working with the Legal System

Psychologists working with claimant populations benefit from developing basic literacy about the legal process. Understanding the basic sequence of a compensation claim—filing, medical assessments, dispute resolution, settlement or trial—allows the psychologist to orient the patient, normalize the process, and anticipate specific stressors. This literacy does not require the psychologist to become an expert in law; rather, it means having sufficient understanding to be a knowledgeable clinical presence.

Building constructive relationships with attorneys who work with claimants, when possible, supports coordinated care. Attorneys can inform therapists about upcoming stressful events (depositions, examinations, court dates) so that therapy can prepare the patient; therapists can inform attorneys, with the patient's consent, about clinical factors relevant to the legal strategy.

8.8 Advocacy at the System Level

The findings reviewed here have implications not only for individual clinical practice but for system-level advocacy. Psychologists have a legitimate role in informing compensation scheme design, case manager training, and public discourse. Specific advocacy priorities suggested by the reviewed literature include:

Reducing procedural delays wherever possible, given the strong association between delay and psychological distress. Improving informational support for claimants, addressing the widespread stress associated with understanding claim requirements. Training case managers in reflective listening and procedural justice practices. Reducing the burden of medical examinations through coordinated multi-purpose assessment. Ensuring access to early psychological intervention for injured individuals at risk of chronic outcomes.

These system-level changes are unlikely to be achieved by individual clinicians alone. However, professional organizations, expert commentary, and public-facing scholarship all contribute to system change over time. The current manual is itself an example of contributing to the knowledge base that supports informed advocacy.

8.9 Self-Care for Psychologists

Working with claimant populations can be emotionally demanding. The chronicity of the presentations, the frustration of watching therapeutic progress impeded by external processes, the ethical complexity of the treatment relationship, and the potential for boundary pressures all contribute to clinician burden. Psychologists working in this area benefit from robust self-care practices, including peer consultation, supervision when appropriate, workload management, and attention to signs of vicarious traumatization or compassion fatigue.

---

9. FUTURE DIRECTIONS AND RESEARCH GAPS

9.1 Methodological Priorities

The reviewed literature identifies several methodological priorities for future research. Elbers et al. (2013) noted that the overall quality of evidence in the field is limited by observational designs, uncertain exposure assessment, non-blinded outcome measurement, and high attrition. Grant et al. (2014) and O'Donnell et al. (2015) demonstrated the value of longitudinal cohort studies with validated measures, random selection, and long-term follow-up, but even their studies are subject to the inherent limits of observational research.

Priorities include: larger prospective cohort studies with standardized measurement time points (recommended by Elbers et al. as at 6, 12, and 24 months post-injury, ideally with pre-injury baseline where feasible); careful assessment of compensation exposure, including scheme type, procedural events, and duration; use of matched controls where randomization is not feasible; and analysis and control of baseline differences between claimant and non-claimant groups.

Development of objective indices of compensation-related stress, complementing self-report measures, would strengthen causal inference. Physiological measures (cortisol, inflammatory markers, heart rate variability), behavioral measures (rehabilitation adherence, return-to-work trajectories), and administrative measures (number of medical examinations, dispute events) could all contribute.

9.2 Mechanism Specification

The reviewed literature has begun to identify specific mechanisms through which compensation processes influence health, but substantial gaps remain. Priority questions include:

Which specific features of compensation processes are most consequential for outcomes? Grant et al. (2014) identified understanding requirements and process duration as leading stressors, but the relative causal contribution of these versus other features requires further examination.

How do specific claim milestones (initiation, dispute, settlement) shape psychological trajectories? The literature has documented mixed findings on the effect of claim settlement on health, and better characterization of the psychological consequences of these transitions is needed.

How do compensation stress and mental health interact bidirectionally over time? The O'Donnell et al. (2015) mediation model provides one framework, but more complex dynamic models capturing feedback loops between symptoms and stress could illuminate the amplification and diminished resources pathways.

9.3 Scheme Design Comparisons

Comparative research across compensation scheme designs is an important priority. If no-fault schemes indeed produce better outcomes than third-party liability schemes, understanding the specific mechanisms would inform scheme reform. Natural experiments arising from legislative changes provide opportunities for quasi-experimental research on scheme effects.

Cross-jurisdictional research also addresses generalizability. The current evidence base is heavily weighted toward Australian, American, and British contexts; extending research to other jurisdictions with different legal traditions and cultural contexts would enhance understanding.

9.4 Intervention Development and Evaluation

The clinical implications of the reviewed evidence generate specific intervention hypotheses that require testing. Stepped-care early psychological intervention, as noted by O'Donnell et al. (2015), has preliminary evidence but requires larger controlled trials specifically in claimant populations.

Interventions targeting the compensation process itself—case manager training, procedural reforms, information provision to claimants—also require evaluation. Randomized rollouts of scheme reforms, where feasible, would provide the strongest evidence.

Interventions integrating clinical and legal support, in which claimants receive coordinated care spanning medical, psychological, and legal dimensions, represent a promising area for development. The evidence base for such integrated models is currently limited.

9.5 Understanding Resilience

Much of the reviewed literature emphasizes negative outcomes, but a substantial proportion of claimants—37% in the O'Donnell et al. (2015) sample—reported no compensation-related stress. Understanding the factors that protect these resilient claimants would inform preventive interventions. Personality factors, social support, financial resources, prior legal experience, and specific coping strategies all deserve investigation.

9.6 Longitudinal Trajectories Beyond Claim Resolution

Most research to date has focused on claimants during the compensation process. Less is known about long-term trajectories following claim resolution. Does resolution provide relief, or do the effects of the process persist? What factors predict recovery versus chronic impairment following settlement? These questions have important implications for post-settlement clinical care and for understanding the long-term footprint of compensation exposure.

9.7 Special Populations

The current literature focuses predominantly on adult claimants with physical injuries from motor vehicle accidents and workplace incidents. Less is known about compensation experiences in other populations: children and adolescents; individuals pursuing claims for

psychological injuries (harassment, discrimination, medical negligence); older adults; individuals with pre-existing psychiatric disorders; and individuals from cultural and linguistic minorities. Each of these populations may have distinctive experiences and needs.

9.8 The Role of Digital and Administrative Innovation

As compensation schemes increasingly adopt digital case management, online portals, and algorithmic decision-support, the psychological implications of these innovations require investigation. Do digital tools reduce or exacerbate the stress of information asymmetry? How do claimants experience algorithmic decisions? These emerging questions will become increasingly important as compensation schemes evolve.

---

10. CONCLUSION

This continuing education manual has synthesized an emerging body of research demonstrating that the process of seeking compensation for personal injury exerts psychological effects distinct from, and additional to, those of the injury itself. Drawing on prospective cohort research (O'Donnell et al., 2015; Grant et al., 2014), a systematic meta-analysis of prospective studies (Elbers et al., 2013), and clinical-scholarly analysis of the litigant-patient (Strasburger, 1999), the manual has developed an integrated framework in which compensation-related stress operates as a chronic psychosocial stressor whose effects on mental health and long-term disability are meaningful, clinically detectable, and potentially modifiable.

Several key conclusions emerge from this synthesis. First, compensation-related stress is prevalent, with substantial minorities of claimants reporting high levels of stress from multiple specific features of the process, most notably procedural opacity and delay. Second, this stress is significantly associated with worse long-term outcomes, including elevated disability, diminished quality of life, and persistent depression and anxiety, even after adjustment for baseline vulnerability. Third, acute post-injury psychopathology—particularly PTSD and depression—amplifies the perceived stressfulness of the compensation process, creating an indirect pathway from acute distress to long-term disability. Fourth, the mechanisms through which these effects operate include diminished coping resources, thwarted psychological

defenses, procedural injustice, repeated trauma reactivation, and disruption of autonomy and control.

These findings have substantial implications for clinical practice. Psychologists working with injured populations should routinely screen for acute psychiatric symptoms, deliver or refer for stepped-care early intervention, address compensation-related concerns as legitimate clinical material, and maintain awareness of the specific transference, countertransference, and boundary considerations that arise in treating litigant-patients. At the system level, the findings support advocacy for scheme reforms that reduce delays, improve informational support, enhance procedural justice, and integrate clinical and legal care.

At the same time, the manual has emphasized the limitations of the current evidence base. The quality of evidence remains constrained by methodological challenges inherent in observational research, and important questions—about the relative contributions of selection and causation, about differential scheme effects, about optimal intervention design—remain incompletely answered. Future research addressing these gaps will refine both the conceptual understanding and the clinical practice of compensation-related psychological care.

Perhaps the deepest implication of this literature is a reframing of what compensation schemes are, in psychological terms. From the standpoint of legal design, compensation schemes are mechanisms for allocating financial responsibility for injury. From the standpoint of the injured person, they are structured environments in which recovery is either supported or impeded. The founding aspiration of compensation schemes is restorative: to return injured persons to health. The evidence reviewed here suggests that, at least for some claimants, current schemes fall short of this aspiration—and that the shortfall reflects modifiable features of the process rather than inevitable consequences of injury.

Psychologists occupy a distinctive position in this landscape. As clinicians, we treat the individuals whose recovery is being shaped by these systems. As researchers, we generate the evidence needed to understand and improve the systems. As advocates, we contribute to the discourse and design of the systems themselves. Effective engagement across these roles requires the kind of integrated understanding that this manual has sought to develop.

The claimant who arrives in our consulting rooms carries not only the wounds of the original injury but the accumulated burden of the process through which they are seeking redress. Recognizing this reality, and responding to it with clinical skill and system awareness, is a

core competence for contemporary psychological practice with injured populations. The evidence supporting this competence is substantial and growing; the clinical and ethical case for exercising it is clear.

---

11. REFERENCES

Elbers, N. A., Hulst, L., Cuijpers, P., Akkermans, A. J., & Bruinvels, D. J. (2013). Do compensation processes impair mental health? A meta-analysis. *Injury*, *44*(5), 674–683.

Grant, G. M., O'Donnell, M. L., Spittal, M. J., Creamer, M., & Studdert, D. M. (2014). Relationship between stressfulness of claiming for injury compensation and long-term recovery: A prospective cohort study. *JAMA Psychiatry*, *71*(4), 446–453.

O'Donnell, M. L., Grant, G., Alkemade, N., Spittal, M., Creamer, M., Silove, D., McFarlane, A., Bryant, R. A., Forbes, D., & Studdert, D. M. (2015). Compensation seeking and disability after injury: The role of compensation-related stress and mental health. *The Journal of Clinical Psychiatry*, *76*(8), e1000–e1005.

Strasburger, L. H. (1999). The litigant-patient: Mental health consequences of civil litigation. *The Journal of the American Academy of Psychiatry and the Law*, *27*(2), 203–211.

End of Manual