The Psychological Impact of Workers' Compensation Systems: Prevalence, Predictors, and Clinical Implications for Mental Health Practice

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

---

Abstract

Workers' compensation systems, established to provide financial support, medical treatment, and rehabilitative services to individuals injured in the course of employment, have become a focus of increasing psychological inquiry due to their paradoxical relationship with claimant mental health. Although these systems were designed to ameliorate the consequences of occupational injury, a growing body of research suggests that engagement with compensation processes is frequently associated with elevated psychological distress, depressive symptomatology, anxiety, and, in the most concerning cases, suicidal ideation and self-harm behaviors. This continuing education manual synthesizes contemporary empirical findings on the psychological sequelae of workers' compensation claims, drawing on a large national Australian survey of claimants (Collie et al., 2020) and a systematic review of the international literature examining associations between workplace injury compensation and mental health outcomes (Wadhwa et al., 2024). The manual explores prevalence rates of psychological distress among claimants, identifies personal, workplace, healthcare-related, and system-level predictors, examines the underutilization of mental health services, and articulates clinical implications for psychologists working with this population. Emphasis is placed on the mechanisms by which claim processes may exacerbate psychological distress, including stressful interactions with insurers, procedural justice concerns, financial strain, and the effects of prolonged work absence. Findings are integrated into a coherent conceptual framework that positions the compensation system itself as a modifiable social determinant of mental health. The manual concludes with recommendations for screening, early intervention, and system-level reform to reduce iatrogenic harm and improve outcomes for injured workers.

---

1. Introduction

Workers' compensation constitutes one of the most extensive systems of social insurance in industrialized nations, serving as the primary vehicle through which governments finance treatment, rehabilitation, and wage replacement for individuals whose injuries or illnesses arise from employment. The scope of these systems is substantial. In the United States, more than 136 million jobs were covered by state or federal workers' compensation schemes in 2016, with combined benefits exceeding $61.9 billion, of which roughly half was allocated to medical services and half to wage replacement (Collie et al., 2020). In Australia, the nine major workers' compensation schemes disbursed approximately $1.9 billion in healthcare and treatment costs to 242,000 injured workers in 2014–2015, in addition to $4.5 billion in wage replacement (Collie et al., 2020). The scale of investment reflects both the frequency of occupational injury and the social contract underlying these systems: workers who are harmed in the course of their labor are entitled to protection and support.

Despite this considerable financial and administrative investment, the psychological experience of claimants often diverges sharply from the intended supportive function of these systems. A recurring finding in the empirical literature is that the process of seeking and receiving workers' compensation is itself associated with poorer psychological outcomes, including elevated depressive symptoms, anxiety, distress, and, in some cases, suicidality (Wadhwa et al., 2024). The compensation process, rather than serving purely as a mechanism of recovery, appears to function as an independent psychological stressor. This paradox—that a system designed to help may in fact contribute to harm—demands the attention of clinical psychologists, who are frequently called upon to evaluate and treat injured workers navigating these systems.

The purpose of this continuing education manual is to provide licensed psychologists and graduate-level clinicians with a comprehensive, evidence-based understanding of the psychological consequences of workers' compensation claims. This includes an examination of prevalence rates, the identification of personal and systemic predictors of distress, an analysis of mental health service utilization patterns, and a critical appraisal of the mechanisms by which the compensation process may contribute to psychological morbidity. Drawing on a large-scale Australian national survey of 3,755 workers' compensation

claimants (Collie et al., 2020) and a systematic review of nine studies examining the compensation–mental health relationship internationally (Wadhwa et al., 2024), this manual synthesizes findings into a coherent framework relevant to clinical practice, policy development, and future research.

The clinical implications of this literature are substantial. Psychologists working with injured workers must contend not only with the primary physical or psychological consequences of the workplace injury but also with the secondary psychological effects generated by the claim process itself. Awareness of these dynamics is essential for accurate case conceptualization, effective treatment planning, and appropriate advocacy on behalf of clients. Moreover, at a broader level, psychologists have a role to play in shaping the design of compensation systems so that they align with, rather than undermine, the therapeutic aims that justify their existence.

---

2. Historical and Theoretical Foundations

The origins of workers' compensation systems lie in early twentieth-century efforts to resolve the social crisis produced by industrial injury. Prior to their establishment, injured workers had few reliable avenues for redress; tort-based systems required proof of employer negligence, were adversarial, and often left injured workers destitute. Workers' compensation legislation introduced a "no-fault" approach in which workers surrendered the right to sue their employer in exchange for guaranteed medical care and wage replacement. This social bargain, replicated across most industrialized nations, was intended to provide predictable and humane support for injured workers while limiting employer liability.

Contemporary compensation schemes vary considerably in structure, eligibility, benefits, and administration. In Australia, eleven separate schemes provide coverage for approximately 94% of the national labor force (Collie et al., 2020). Individual states and territories operate their own systems, resulting in variability in payments, assessment processes, eligibility criteria, and duration of coverage. In the United States, workers' compensation is administered at the state level, with substantial variation across jurisdictions. Canada similarly operates through provincial systems. Despite this heterogeneity, common features include the distinction between "lost-time" and "medical-only" claims, criteria for accepting or contesting

claims, and processes for adjudicating disputes.

The theoretical foundation for understanding the psychological effects of workers' compensation draws from several disciplinary traditions. The Sherbrooke model of work disability, referenced in the empirical literature (Collie et al., 2020), articulates a multidimensional framework in which recovery from work-related injury is shaped by the interaction of four domains: personal characteristics of the worker, features of the workplace, characteristics of the compensation scheme, and the healthcare system. This model represents a substantial departure from purely biomedical conceptualizations of recovery, recognizing that psychological, social, and administrative factors are integral to functional outcomes.

Procedural justice theory offers a complementary theoretical lens. Drawing on organizational psychology and social justice research, procedural justice frameworks emphasize that individuals' perceptions of fairness in the processes by which decisions are made independently influence psychological wellbeing, over and above the outcomes themselves. Applied to workers' compensation, this framework suggests that the perceived fairness of claim adjudication, the transparency of decision-making, and the quality of interactions with case managers and insurers exert distinct effects on claimant mental health (Wadhwa et al., 2024). Empirical work supports this proposition: workers who perceive their claim process as unfair report poorer mental health outcomes than those who perceive their treatment as just.

The stress and coping literature provides additional theoretical grounding. From this perspective, the compensation process functions as a chronic stressor, characterized by uncertainty, loss of control, and demands that may exceed individuals' coping resources. Prolonged exposure to such stressors can produce sustained activation of psychological and physiological stress responses, contributing to the development of depressive, anxious, and traumatic symptomatology. This framework helps explain why claimants often report deterioration in mental health over the course of their engagement with compensation systems, even when their physical injuries are stable or improving.

Finally, ecological and social determinants of health perspectives contextualize the individual claimant within broader structural systems. The workers' compensation process operates at the intersection of employment, healthcare, insurance, and government—each with its own bureaucratic logic and power differentials. Injured workers frequently occupy a position of relative powerlessness within this ecosystem, navigating complex administrative processes

while simultaneously coping with pain, disability, and financial uncertainty. Understanding claimant distress as arising from this structural context, rather than solely from individual pathology, has important implications for how psychologists conceptualize and intervene in these cases.

---

3. Conceptual Models and Mechanisms

To understand how workers' compensation systems affect mental health, it is useful to articulate the specific mechanisms through which the claim process may produce psychological distress. The empirical literature supports the identification of several interrelated pathways, which together constitute a conceptual model of the compensation–mental health relationship.

The first mechanism concerns the direct psychological impact of the underlying injury. Physical injury, particularly injury of sufficient severity to require time away from work, produces predictable psychological sequelae including grief over lost function, anxiety about recovery, and, in some cases, post-traumatic stress. This baseline effect of injury is well documented; depressive symptoms are common following musculoskeletal injuries, with cumulative incidence rates as high as 50% at twelve months in some studies (Collie et al., 2020). Kim (2013), cited in both source documents, demonstrated that individuals experiencing occupational injuries and receiving workers' compensation had 33% higher odds of developing depression compared to non-injured workers, with the effect increasing over time.

A second mechanism operates through the disruption of work identity and role. Employment provides more than financial resources; it structures time, generates social relationships, and contributes to self-concept. Prolonged absence from work erodes these psychological benefits, producing symptoms of demoralization, isolation, and identity confusion. The empirical evidence supports this pathway. Collie et al. (2020) found that workers currently off work reported dramatically higher rates of severe psychological distress (37%) than those who had returned to work (8%). The magnitude of this association—an adjusted odds ratio of 1.54 after controlling for other factors—indicates that work absence is not merely a marker of injury severity but exerts independent effects on mental health.

A third mechanism relates to financial stress. Although workers' compensation is intended to replace lost wages, the adequacy and timeliness of these payments vary considerably. Financial stress emerged as one of the strongest predictors of psychological distress in the Collie et al. (2020) analysis, with high financial stress associated with 2.63 times the odds of elevated distress. This finding aligns with a substantial body of research demonstrating that economic insecurity is a robust determinant of mental health outcomes across diverse populations.

A fourth pathway involves interactions with the workers' compensation system itself. This mechanism has received increasing empirical attention and appears to be one of the most clinically significant contributors to claimant distress. Stressful interactions with insurers, case managers, and healthcare providers have been consistently associated with poorer mental health outcomes. Kilgour, Kosny, McKenzie, and Collie (2015), cited in both source documents, documented through systematic qualitative review that injured workers frequently describe their interactions with insurers as adversarial, dehumanizing, and stigmatizing. Grant, O'Donnell, Spittal, Creamer, and Studdert (2014), also cited across the source materials, demonstrated in a prospective cohort study that the stressfulness of the compensation-claiming process predicted long-term recovery, including psychological outcomes, six years after physical injury.

A fifth mechanism concerns procedural justice and perceived fairness. When claimants perceive that they are being treated fairly—that decisions are made transparently, that their voice is heard, and that they are treated with respect—their psychological outcomes are more favorable than when they perceive the process as arbitrary or hostile. Hepburn, Kelloway, and Franche (2010), referenced by Collie et al. (2020), demonstrated that early employer response to workplace injury shapes workers' perceptions of fairness, which in turn influences attitudes toward return to work and mental health. Elbers, Collie, Hogg-Johnson, Lippel, Lockwood, and Cameron (2016) further demonstrated differences in perceived fairness and health outcomes across compensation systems, suggesting that the structural features of the system itself shape claimant experiences.

A sixth mechanism operates through healthcare access and quality. Workers' compensation typically funds treatment only for the specific condition for which liability has been accepted, meaning that comorbid conditions—including psychological conditions that arise secondary to the physical injury—may not be covered. This creates structural barriers to mental health

treatment for the substantial subgroup of claimants who develop psychological distress in the wake of their injuries. Additionally, healthcare providers themselves often report knowledge barriers regarding insurance processes, and stressful interactions between claimants and providers were identified by Collie et al. (2020) as significantly associated with elevated distress (AOR = 2.16).

A seventh mechanism involves stigma and social attribution. Injured workers frequently describe experiencing skepticism from employers, healthcare providers, insurers, and even family members regarding the legitimacy of their injuries. This phenomenon is particularly pronounced for injuries that lack visible manifestations, such as chronic musculoskeletal pain or psychological conditions. The experience of being disbelieved or characterized as malingering contributes to psychological distress and may deter help-seeking (Wadhwa et al., 2024).

Figure 1 (described conceptually) would illustrate these mechanisms as a network of interacting pathways: the initial injury generates direct psychological effects while simultaneously initiating engagement with the compensation system; the system, through its administrative processes and the quality of its interpersonal interactions, either mitigates or exacerbates the underlying distress; financial and occupational disruptions further compound psychological burden; and the availability and quality of healthcare, including mental health services, shape the trajectory of recovery. This model emphasizes that the compensation system is not a neutral conduit for services but an active determinant of psychological outcomes.

---

4. Empirical Findings Across Studies

The empirical literature examining the psychological consequences of workers' compensation, while still developing, has produced a coherent body of evidence supporting the proposition that engagement with compensation systems is associated with adverse mental health outcomes. This section synthesizes findings across the two source documents, integrating results from the large-scale Australian survey (Collie et al., 2020) with the systematic review synthesizing nine international studies (Wadhwa et al., 2024).

The Collie et al. (2020) study represents one of the most substantive investigations of psychological distress in workers' compensation claimants conducted to date. Drawing on the biennial National Return to Work Survey administered in Australia, the study included 3,755 workers with accepted workers' compensation claims, comprising 3,160 with musculoskeletal disorders and 595 with mental health conditions. Using the Kessler 6 scale, a well-validated screening instrument for psychological distress, the researchers found that 41.6% of respondents met criteria for moderate or severe psychological distress. Specifically, 27.5% were classified as having moderate distress and 14.0% as having severe distress. The severity of this finding is underscored by comparison to the general Australian working-age population, in whom the prevalence of severe psychological distress is approximately 4.0%. Workers' compensation claimants thus exhibited severe distress at more than three times the national average.

Even more striking were the findings within specific subgroups. Among claimants not currently working, the prevalence of severe distress reached 37.3%, approximately nine times the national average. Among those with claims for mental health conditions, the prevalence was 26.7%, roughly six times the national average. Perhaps most concerning from a public health perspective, 37.9% of claimants with musculoskeletal disorders—the most common type of compensation claim—reported moderate or severe psychological distress within two years of their claim. Given that musculoskeletal disorders constitute the majority of workers' compensation claims internationally, this finding suggests that a substantial proportion of the injured worker population experiences clinically significant psychological distress.

The systematic review by Wadhwa et al. (2024) examined nine studies published between 2001 and 2020 that investigated associations between workers' compensation and mental health or self-harm outcomes. The review documented a general pattern of adverse associations. Kim (2013), included in the review, demonstrated using longitudinal data from the Medical Expenditure Panel Survey that workers with occupational injuries receiving workers' compensation had 33% higher odds of developing depression than uninjured workers, with the effect strengthening over time. Hee (2001), also included in the review, found that spinal disorder patients receiving workers' compensation exhibited significantly lower mental health scores on the SF-36 than those not receiving compensation, even after adjustment for covariates. Wall, Morrissey, and Ogloff (2008) compared current claimants, previous claimants, and non-claimants and found that current claimants exhibited significantly higher depression scores than non-claimants.

Two studies examining suicidality yielded particularly concerning findings. Applebaum, Asfaw, O'Leary, and colleagues (2019) investigated mortality outcomes among workers with lost-time injuries in New Mexico. Workers experiencing lost-time injuries had significantly elevated risks of suicide compared to those receiving only medical-only compensation, with hazard ratios of 1.72 for men and 1.92 for women. Fishbain, Bruns, Disorbio, and colleagues (2009) examined suicidality among rehabilitation patients receiving workers' compensation and those undergoing litigation, comparing them to healthy community controls. Rehabilitation patients with workers' compensation exhibited elevated risks across all three suicide indicators examined: suicidal intent (RR = 2.64), suicide plan (RR = 5.95), and history of suicide attempt (RR = 2.88). Risks were even higher among those involved in litigation, with a suicide plan risk ratio of 6.37. King, Disney, Sutherland, and colleagues (2023), referenced within Wadhwa et al. (2024), similarly documented associations between workers' compensation and self-harm hospitalizations.

The convergence of findings across studies with varying methodologies, populations, and outcome measures lends credibility to the overall pattern. Nevertheless, the heterogeneity of comparison groups, exposure definitions, and outcome measurements creates challenges for precise quantitative synthesis. Some studies compared claimants to healthy controls, others to injured workers not making claims, and still others to workers with medical-only claims. Similarly, mental health outcomes were assessed using diverse instruments including the K-6, GHQ-28, BHI-2, SF-36, and structured clinical interviews. These methodological variations preclude formal meta-analysis but do not undermine the qualitative consistency of the findings.

Table 1 (described in text) would summarize the key findings across the primary studies, presenting for each study the population examined, the exposure and comparator groups, the outcome measures employed, and the principal effect estimates. Such a table would reveal that despite methodological heterogeneity, the direction of effect is consistently unfavorable for workers' compensation claimants, with effect sizes ranging from modest (odds ratios in the 1.3 range) to substantial (relative risks exceeding 5).

Critical appraisal of this literature reveals several methodological limitations. Most studies employed cross-sectional designs, limiting causal inference. Selection effects may operate at multiple levels: workers who develop mental health problems may be more likely to file claims, and workers with certain baseline characteristics may be more likely to be captured in study samples. Reverse causation cannot be excluded—poor mental health may contribute to

occupational injury risk rather than resulting from it. Furthermore, unmeasured confounding, particularly from pre-injury mental health status, workplace conditions, and socioeconomic factors, may bias observed associations. Despite these limitations, the consistency of findings across diverse methodological approaches, along with the biological and psychological plausibility of the proposed mechanisms, supports the general conclusion that engagement with workers' compensation systems is associated with elevated psychological morbidity.

---

5. Psychological Pathways and Stress Responses

The transition from workplace injury to sustained psychological distress unfolds through identifiable psychological pathways that merit close attention from clinicians. Understanding these pathways not only illuminates the mechanisms by which compensation systems affect mental health but also identifies points of potential clinical intervention.

The initial psychological response to workplace injury typically involves acute stress reactions, including anxiety, hyperarousal, and preoccupation with the injury and its implications. For workers whose injuries occur suddenly or traumatically, symptoms of acute stress disorder or, subsequently, post-traumatic stress disorder may develop. Even in the absence of a discrete traumatic event, the experience of injury—with its attendant pain, functional limitation, and uncertainty—constitutes a significant psychological stressor. Craig, Tran, Guest, Gopinath, Jagnoor, Bryant, and colleagues (2016), cited in Collie et al. (2020), documented substantial psychological impacts of injuries sustained in motor vehicle crashes, with parallel findings applying to occupational injuries.

Following the acute phase, workers enter a period during which they must simultaneously cope with their injury, engage with medical treatment, and initiate a claim through the compensation system. This period is characterized by considerable uncertainty regarding recovery trajectory, work status, and financial stability. From a stress and coping perspective, this constitutes exposure to multiple concurrent stressors, each with the potential to overwhelm individual coping resources. The extent to which workers can mobilize social support, maintain a sense of agency, and access effective coping strategies moderates the psychological impact of these stressors.

The claims process itself introduces distinctive psychological demands. Workers must document their injuries, articulate the circumstances of their occurrence, and often defend the legitimacy of their claims against implicit or explicit skepticism. The bureaucratic complexity of compensation systems—with their forms, deadlines, medical evaluations, and appeals processes—demands cognitive and emotional resources that may already be depleted by injury and treatment. Collie et al. (2020) found that workers who required support to navigate the claims system exhibited significantly elevated psychological distress (AOR = 1.29), suggesting that the demands of the system itself constitute a psychological burden.

The interactions between claimants and system actors—case managers, insurers, healthcare providers, employers, and return-to-work coordinators—shape the psychological experience of the claim process. When these interactions are perceived as supportive, transparent, and respectful, they can buffer distress and facilitate recovery. When they are perceived as adversarial, dismissive, or demeaning, they exacerbate distress and undermine coping. The findings from Collie et al. (2020) are illustrative: workers reporting stressful contact with return-to-work coordinators had an AOR of 1.55 for elevated distress, and workers reporting stressful interactions with healthcare providers had an AOR of 2.16. The consistency of these findings across different types of system actors suggests that the quality of interpersonal interactions within the compensation ecosystem exerts a systematic effect on psychological outcomes.

Financial stress emerges as a particularly potent psychological pathway. Workers' compensation payments, while intended to replace lost wages, are often inadequate to maintain pre-injury standards of living, particularly for higher-earning workers or those with substantial fixed expenses. Delays in payments, disputes over eligibility, and periodic reviews create ongoing financial uncertainty. The psychological effects of this uncertainty extend beyond the immediate concern about money to encompass broader existential concerns about security, provision for family, and the future. Collie et al. (2020) found that workers reporting high financial stress had 2.63 times the odds of elevated psychological distress, and workers whose main source of income was workers' compensation (rather than wages) had 1.58 times the odds of distress.

Concern about the workplace response to the claim represents another significant pathway. Workers who anticipate or experience negative reactions from employers—including doubt about the legitimacy of their claims, pressure to return to work prematurely, or overt hostility—experience heightened distress. This is captured in the Collie et al. (2020) analysis

by the "concerns about submitting claim" variable, with workers reporting high concerns exhibiting 2.31 times the odds of elevated distress compared to those with low concerns. The subjective perception of workplace unfairness thus operates as an important psychological stressor.

Chronic pain constitutes a further psychological pathway. Workers with persistent physical pain, particularly pain that limits function and disrupts sleep, experience cascading psychological effects including depression, anxiety, irritability, and reduced quality of life. Collie et al. (2020) found that workers reporting pain in the past week had 1.91 times the odds of elevated distress. The interaction between chronic pain and psychological distress is bidirectional: pain contributes to distress, and distress amplifies the experience of pain, producing self-reinforcing cycles that can become progressively more difficult to interrupt.

Reduced work ability integrates multiple pathways into a single indicator with strong psychological significance. Workers who perceive themselves as unable to perform their work tasks experience diminished self-efficacy, loss of occupational identity, and anticipatory anxiety about the future. Collie et al. (2020) found that low work ability was among the strongest predictors of psychological distress, with adjusted odds ratios of 3.12 for workers with musculoskeletal disorders and 7.04 for those with mental health conditions. The particularly large effect among those with mental health conditions suggests a synergistic interaction whereby the combination of psychological injury and impaired work capacity produces severe distress.

These psychological pathways operate concurrently rather than sequentially, with each pathway both influencing and being influenced by the others. Financial stress heightens sensitivity to workplace responses; workplace concerns amplify perception of pain; pain limits work ability; reduced work ability worsens financial stress. Understanding this network of interacting pathways is essential for effective clinical intervention, as targeting any single pathway in isolation is likely to produce limited benefit.

---

6. Mental Health Outcomes and Severity Spectrum

The mental health outcomes observed among workers' compensation claimants span a broad severity spectrum, from subclinical distress to severe psychiatric illness and, in the most concerning cases, suicidal behavior. Understanding this spectrum is essential for accurate assessment and appropriate clinical intervention.

At the mildest end of the spectrum, many claimants experience subclinical psychological distress that, while not meeting criteria for a psychiatric disorder, nonetheless impairs quality of life and functional capacity. This distress may manifest as heightened worry, sleep disturbance, irritability, and difficulty concentrating. Even at this level, distress may impede recovery, disrupt family relationships, and undermine return-to-work efforts.

Moderate psychological distress, as captured by Kessler 6 scores of 11 to 18, represents a clinically significant level of symptomatology warranting attention. Collie et al. (2020) identified 27.5% of their sample as meeting criteria for moderate distress. Workers at this level frequently exhibit depressive and anxious symptoms that, while potentially not meeting full diagnostic criteria for a major depressive or anxiety disorder, nonetheless produce meaningful impairment.

Severe psychological distress, indicated by Kessler 6 scores of 19 to 30, represents a level of symptomatology that typically corresponds to a diagnosable psychiatric disorder. The 14.0% prevalence identified by Collie et al. (2020) among all claimants, rising to 37.3% among those not currently working and 45% among those with mental health condition claims and low work ability, indicates that severe psychiatric morbidity is common in this population.

Depressive disorders represent the most extensively documented mental health outcome in workers' compensation claimants. The literature reviewed by Wadhwa et al. (2024) consistently identified elevated rates of depression among claimants across multiple studies. Franche, Carnide, Hogg-Johnson, Cote, Breslin, and Bultmann (2009), cited in Collie et al. (2020), reported that depressive symptoms are common following workplace injury, with Carnide, Franche, Hogg-Johnson, Cote, Breslin, and Severin (2016) documenting a 12-month cumulative incidence of depressive symptoms of 50% in one Canadian cohort. Importantly, depressive symptoms delay return to work and complicate recovery, meaning that untreated depression contributes to prolonged disability.

Anxiety disorders similarly occur at elevated rates. Kim (2013) and others have documented associations between workers' compensation and anxiety symptomatology. The uncertainty

inherent in the claim process, the anticipatory concerns about work capacity and financial security, and the ongoing interactions with system actors all provide fertile ground for the development and maintenance of anxious symptomatology.

Comorbidity between depression and anxiety appears particularly common and clinically significant. Collie et al. (2020) found that workers with musculoskeletal disorders diagnosed with both depression and anxiety exhibited 3.94 times the odds of elevated psychological distress compared to those without such diagnoses. This finding underscores that when both conditions are present, the psychological burden is substantially amplified.

Post-traumatic stress and related conditions are documented, particularly among workers whose injuries occurred in traumatic circumstances or among certain occupational groups such as emergency service personnel. O'Donnell, Grant, Alkemade, and colleagues (2015), cited in Wadhwa et al. (2024), documented the role of compensation-related stress and mental health in disability outcomes following injury. Post-traumatic stress symptoms may complicate the assessment of injury-related distress, as symptoms may be attributed variously to the injury itself, the circumstances of injury, or the claim process.

Chronic pain with psychological features—including pain that has become the focus of substantial emotional distress and functional impairment—represents another significant clinical presentation. The intersection of chronic pain and psychological distress is complex, with each condition amplifying the other. Dersh, Gatchel, Mayer, Polatin, and Temple (2006), cited in Collie et al. (2020), documented high prevalence of psychiatric disorders among patients with chronic disabling occupational spinal disorders.

Suicidality represents the most severe end of the outcome spectrum and warrants particular clinical attention. The findings from Applebaum et al. (2019) and Fishbain et al. (2009) documenting elevated suicide risk among workers with lost-time injuries and among rehabilitation patients with workers' compensation are deeply concerning. The hazard ratios of 1.72 to 1.92 for suicide mortality reported by Applebaum et al. (2019), and the relative risks of 2.64 to 6.37 for various suicide indicators reported by Fishbain et al. (2009), indicate substantially elevated risk. Barr, Taylor-Robinson, Stuckler, and colleagues (2016), cited in Wadhwa et al. (2024), similarly documented associations between disability assessments and adverse mental health trends, including suicide.

Understanding the severity spectrum has direct implications for clinical practice. Psychologists working with workers' compensation claimants should routinely assess across the full range of severity, from subclinical distress through severe psychiatric illness and suicidal ideation. Screening for suicidality is particularly important given the elevated risk documented in this population. Assessment should be repeated over time, as psychological status may deteriorate over the course of a prolonged claim process.

---

7. System-Level and Contextual Psychological Effects

Beyond individual-level psychological outcomes, workers' compensation systems produce contextual effects that shape the psychological experience of claimants in aggregate. These system-level effects merit examination because they represent modifiable features of the compensation environment with potential implications for reform.

The adversarial nature of many compensation processes represents perhaps the most significant system-level factor affecting claimant psychology. Although workers' compensation was originally designed as a "no-fault" system to avoid the adversarial character of tort litigation, contemporary compensation systems often exhibit substantial adversarial features in practice. Claims may be contested by insurers, medical evaluations may be conducted with an eye toward challenging the claim, and disputes may require formal adjudication. Kilgour, Kosny, Akkermans, and Collie (2015), cited in Collie et al. (2020), documented procedural justice concerns in the use of independent medical evaluations in workers' compensation. Pollard (2014), cited in Wadhwa et al. (2024), documented injured teachers' experiences of the Victorian workers' compensation stress claims process as "adversarial and alienating."

The complexity of compensation systems produces additional contextual effects. Claimants must navigate multiple bureaucratic processes, understand technical terminology, meet deadlines, and coordinate across multiple entities including their employer, healthcare providers, insurers, and government agencies. This complexity is particularly burdensome for workers with limited educational resources, language barriers, or cognitive impairments related to their injuries. Roberts-Yates (2003), cited in Wadhwa et al. (2024), documented the concerns of injured workers regarding claims management, injury management, and rehabilitation, highlighting the need for new operational frameworks.

Power imbalances between claimants and system actors constitute another important contextual effect. Injured workers typically enter the compensation process with limited knowledge of their rights, procedural options, and strategic considerations. Insurers, in contrast, possess substantial expertise, resources, and organizational capacity. This asymmetry can produce feelings of powerlessness and vulnerability among claimants, contributing to distress. Mongeau, Lightfoot, MacEwan, and colleagues (2021), cited in Wadhwa et al. (2024), documented workers' perceptions of gaps and failures in union, employer, and compensation systems.

Case manager interactions warrant specific attention as a modifiable system-level factor. Orchard, Carnide, and Smith (2020) and Orchard, Carnide, Smith, and colleagues (2021), cited in Wadhwa et al. (2024), documented associations between case manager interactions and mental health outcomes, including serious mental illness. Workers who experience their case managers as fair, communicative, and supportive report better mental health outcomes than those who perceive their case managers as adversarial or arbitrary. This finding suggests that training and support for case managers, along with organizational structures that incentivize positive interactions, could produce meaningful improvements in claimant outcomes.

Delays and disputes constitute additional system-level stressors. Dawson (1994), cited in Wadhwa et al. (2024), documented the effects of delayed contested cases in Pennsylvania workers' compensation, highlighting how procedural delays exacerbate distress. When claims are delayed, workers face prolonged uncertainty, financial strain, and often the need to advance out-of-pocket for medical expenses. Morse, Dillon, Warren, and colleagues (1998), cited in Wadhwa et al. (2024), documented the economic and social consequences of work-related musculoskeletal disorders in Connecticut, including out-of-pocket healthcare expenses.

Gender-related dimensions of the compensation experience merit consideration. Lippel (1999), cited in Wadhwa et al. (2024), examined workers' compensation and stress with attention to gender and access to compensation. Calvey and Jansz (2005), cited in Wadhwa et al. (2024), specifically documented women's experiences of the workers' compensation system. These studies indicate that gender may shape the experience of compensation processes, potentially producing differential exposure to certain stressors.

Stigmatization represents another important contextual dimension. Injured workers, particularly those with conditions that lack visible manifestations, frequently report experiencing stigma from employers, colleagues, healthcare providers, and even family members. Reid, Ewan, and Lowy (1991), cited in Wadhwa et al. (2024), documented women's illness experiences with repetition strain injury and their search for credibility. The experience of not being believed or being characterized as malingering contributes to psychological distress and may deter help-seeking.

The design of the healthcare system within workers' compensation produces further contextual effects. Because compensation typically funds treatment only for the specific condition for which liability has been accepted, comorbid or subsequent conditions may not be covered. This creates structural barriers to mental health treatment for claimants whose psychological distress develops in the wake of their physical injuries. Kilgour, Kosny, McKenzie, and Collie (2015), cited in Collie et al. (2020), documented how healthcare provider interactions with injured workers and insurers can either heal or harm. Brijnath, Mazza, Singh, Kosny, Ruseckaite, and Collie (2014), cited in Collie et al. (2020), provided qualitative insights into mental health claims management and return to work in Melbourne. Mazza, Brijnath, Singh, Kosny, Ruseckaite, and Collie (2015), also cited, documented general practitioners' experiences with sickness certification for injury in Australia.

Cross-jurisdictional variation offers a natural experiment demonstrating the influence of system design on outcomes. Different jurisdictions employ different compensation designs, and evidence suggests these design differences produce meaningfully different outcomes for claimants. Collie, Lane, Hassani-Mahmooei, Thompson, and McLeod (2016), cited in Collie et al. (2020), documented differences in time off work by jurisdiction across Australian workers' compensation systems. Elbers et al. (2016), cited in Collie et al. (2020) and Wadhwa et al. (2024), documented differences in perceived fairness and health outcomes across compensation systems. These findings support the view that compensation system design is not merely a technical matter but a determinant of population mental health.

---

8. Predictors of Psychological Distress: A Multivariate Perspective

Understanding the predictors of psychological distress among workers' compensation claimants requires attention to the multiple domains that influence outcomes. The comprehensive multivariate analysis conducted by Collie et al. (2020) provides the most detailed available characterization of these predictors, incorporating variables from the worker, workplace, compensation scheme, and healthcare domains as articulated by the Sherbrooke model.

Among worker-level factors, general health status emerged as one of the strongest predictors of psychological distress. Workers reporting poor, fair, or good general health had 2.41 times the odds of elevated distress compared to those with very good or excellent health among those with musculoskeletal disorders, and 6.72 times the odds among those with mental health conditions. This finding highlights the bidirectional relationship between physical and psychological health: physical impairment contributes to psychological distress, and psychological distress may amplify perceptions of physical impairment.

Age exhibited a modest but significant association with distress, with younger workers (ages 18–35 and 36–50) exhibiting somewhat higher odds of distress compared to older workers (51–80). This pattern may reflect the greater long-term implications of injury for younger workers, including concerns about career trajectory, family responsibilities, and lifetime earning capacity.

Diagnosed mental health conditions represented a particularly potent predictor. Workers with musculoskeletal disorders diagnosed with both depression and anxiety had 3.94 times the odds of elevated distress, and even those diagnosed with either depression or anxiety alone had 1.81 times the odds. This finding underscores the importance of assessing for pre-existing or comorbid mental health conditions in the workers' compensation population.

Work ability, as rated by workers themselves on a scale from 1 to 10, emerged as one of the strongest predictors of distress. Low work ability was associated with 3.12 times the odds of distress among workers with musculoskeletal disorders and 7.04 times the odds among those with mental health conditions. The subjective perception of impaired work capacity thus appears to integrate multiple psychological pathways into a single robust indicator.

Physical pain in the past week was associated with 1.91 times the odds of elevated distress, reflecting the well-established relationship between chronic pain and psychological symptomatology.

Among workplace factors, current working status emerged as a critical predictor. Workers currently off work had 1.54 times the odds of elevated distress compared to those working, even after adjustment for other factors. Given the strong crude association (dropping from 6.00 in unadjusted analysis to 1.54 after adjustment), it is clear that work status operates through multiple pathways, but retains an independent effect on distress.

Job stressfulness demonstrated a dose-response relationship with psychological distress. Workers rating their jobs as moderately stressful had 1.35 times the odds of elevated distress, and those rating their jobs as highly stressful had 1.63 times the odds, compared to those rating their jobs as low in stress.

Interactions with return-to-work coordinators showed important patterns. While the absence of a return-to-work coordinator was not itself associated with elevated distress, workers reporting stressful interactions with their coordinators had 1.55 times the odds of distress.

Concerns about the workplace response to the claim submission emerged as a particularly strong predictor. Workers reporting high concerns had 2.31 times the odds of distress compared to those with low concerns, and moderate concerns were associated with 1.74 times the odds.

Among compensation scheme factors, having workers' compensation as the main source of income (rather than wages) was associated with 1.58 times the odds of elevated distress. This finding may reflect both the inadequacy of compensation payments relative to wages and the psychological significance of being on compensation rather than employed.

Requiring support to navigate the claims system was associated with 1.29 times the odds of elevated distress, suggesting that the complexity of the compensation process itself constitutes a psychological burden.

Financial stress emerged as one of the most substantial predictors, with high financial stress associated with 2.63 times the odds of elevated distress.

Among healthcare-related factors, stressful interactions with healthcare providers were associated with 2.16 times the odds of elevated distress, highlighting the importance of the healthcare relationship in shaping psychological outcomes.

Table 2 (described conceptually) would present a comprehensive summary of these predictors, organized by domain, with adjusted odds ratios and confidence intervals. Such a table would reveal that predictors span multiple domains—individual, workplace, compensation scheme, and healthcare—and that the strongest predictors typically involve interactions between the injured worker and system actors, along with the direct experience of impairment and financial stress.

The multivariate analysis also reveals important interactions between injury type and other predictors. The effects of poor general health and low work ability were substantially amplified among workers with mental health condition claims compared to those with musculoskeletal disorder claims. This suggests that the compensation experience differs meaningfully for workers with different types of claims, with mental health claimants potentially facing distinctive challenges.

Critical appraisal of this predictive model reveals both strengths and limitations. Strengths include the large sample size, the use of validated measurement instruments, the incorporation of variables spanning multiple domains, and the rigorous multivariate analysis. Limitations include the cross-sectional design, which precludes causal inference, and the reliance on self-report for both predictor and outcome variables. Nonetheless, the resulting model provides a valuable framework for clinical assessment and for identifying targets for intervention.

---

9. Mental Health Service Utilization

A critical finding from the empirical literature concerns the substantial gap between the prevalence of psychological distress among workers' compensation claimants and their utilization of mental health services. This gap has profound clinical and policy implications.

Collie et al. (2020) documented striking disparities in mental health service utilization based on the nature of the compensation claim. Among workers with mental health condition claims, 91.1% reported accessing specialist mental health services, and 94.5% of those with moderate or severe psychological distress reported such access. This near-universal service utilization reflects the direct alignment between claim type and service need: workers whose

claims are explicitly for mental health conditions are treated within the mental health system.

In contrast, service utilization among workers with musculoskeletal disorder claims was substantially lower, even among those with clinically significant psychological distress. Of workers with musculoskeletal disorder claims and moderate psychological distress, only 20.5% reported accessing mental health services. Even among those with severe psychological distress, only 42.3% reported accessing services. Aggregated across the moderate and severe distress subgroups, only 27.2% of workers with musculoskeletal disorders and psychological distress reported accessing mental health professionals.

This finding indicates that the majority of workers with musculoskeletal disorders and clinically significant psychological distress do not receive specialist mental health treatment. Given the well-established evidence that untreated psychological distress delays return to work, complicates recovery, and contributes to chronic disability (Franche et al., 2009; Cullen, Irvin, Collie, Clay, Gensby, Jennings, and colleagues, 2018, both cited in Collie et al., 2020), this treatment gap represents both a clinical failing and a public health concern.

The predictors of mental health service utilization among workers with musculoskeletal disorders and psychological distress illuminate the factors that facilitate or impede access to care. Severe psychological distress was associated with 2.06 times the odds of accessing services compared to moderate distress, indicating that severity of symptoms does drive some service seeking, though clearly at inadequate rates. Being off work was associated with 2.00 times the odds of service utilization, suggesting that workers who are unable to work are more likely to access mental health services, potentially reflecting greater symptom severity, greater available time, or greater engagement with the healthcare system.

Poor general health was associated with 1.76 times the odds of service utilization, indicating that workers with greater overall health burden are more likely to access mental health care. Requiring support to navigate the claims system was associated with 1.81 times the odds of service use, suggesting that workers seeking assistance more generally may be more likely to seek mental health support specifically.

Notably, several predictors related to interactions with the compensation system were associated with greater service utilization. Workers reporting difference of opinion with their claim organization had 1.53 times the odds of accessing services, and those reporting a lot of contact with the claim organization had 1.62 times the odds. Stressful interactions with

healthcare providers were associated with 1.58 times the odds of service use. These findings suggest that workers who are more embroiled in compensation system conflicts may be more likely to access mental health services, though the direction of causation is unclear.

Industry variations were also observed, with workers in education and training having 2.12 times the odds of service utilization, and public administration and safety workers having 1.76 times the odds, compared to those in secondary industries. These variations may reflect differences in cultural acceptability of mental health treatment, availability of employee assistance programs, or health literacy across occupations.

The reasons for the substantial gap in mental health service utilization among workers with musculoskeletal disorders are multifaceted. Structural barriers include the design of compensation systems that typically fund treatment only for the specific compensable condition. If liability has been accepted for a musculoskeletal disorder, treatment for depression or anxiety arising in the wake of that injury may not be covered, requiring workers to seek treatment through other means. Kilgour, Kosny, McKenzie, and Collie (2015), cited in Collie et al. (2020), documented these barriers.

Knowledge barriers on the part of healthcare providers also contribute. General practitioners and other primary care providers may not routinely screen for psychological distress in patients presenting with musculoskeletal injuries, and even when distress is identified, they may lack familiarity with the mental health referral process within compensation systems.

Stigma constitutes another significant barrier. Workers may hesitate to seek mental health treatment for fear of being perceived as psychologically weak, malingering, or having their physical claim undermined. The fear that a mental health diagnosis will complicate their compensation claim may deter help-seeking.

The compensation system itself may create disincentives to mental health treatment. If insurers perceive mental health treatment as expanding the scope of the claim or as extending the duration of disability, they may discourage such treatment. Concerns about the affordability of workers' compensation insurance may lead insurers to resist funding mental health care that is not directly tied to the compensable condition.

Comparison with the general population is instructive. Australian population data suggest that approximately 9% of persons with diagnosed mental illness access psychiatry services and

14% access psychology services. The rates observed among workers' compensation claimants, while inadequate given the severity of distress, are actually higher than these general population rates, suggesting that the workers' compensation context does facilitate some access to mental health care, but not at rates commensurate with need.

The clinical implications of this service utilization gap are substantial. Psychologists working with injured workers must be alert to the possibility that many of their potential patients have not accessed care despite clinically significant symptoms. Screening programs, active outreach, and streamlined referral pathways could substantially improve access. At the system level, reforms to compensation policies to more explicitly fund treatment for psychological conditions arising from compensable physical injuries would remove an important structural barrier.

---

10. Clinical Implications for Psychologists

The empirical findings synthesized in this manual have direct implications for clinical practice with workers' compensation claimants. Psychologists working with this population must integrate awareness of the compensation context into every aspect of assessment, treatment, and case management.

Comprehensive assessment must extend beyond the presenting problem to encompass the multiple domains that shape psychological outcomes. Consistent with the Sherbrooke model, assessment should address individual factors (including pre-injury mental health, coping resources, and current symptoms), workplace factors (including the nature of the pre-injury work, relationships with supervisors and colleagues, and the workplace response to injury), compensation scheme factors (including the current status of the claim, interactions with case managers, financial stress, and support needs), and healthcare factors (including the nature and quality of current treatment relationships). Screening for the full spectrum of mental health outcomes—from subclinical distress through severe depression, anxiety, post-traumatic stress, and suicidality—should be routine, with the recognition that this population exhibits elevated risk across the severity spectrum.

Screening for suicidality warrants particular attention. Given the elevated suicide risk documented among workers' compensation claimants, especially those with lost-time injuries, structured assessment of suicidal ideation, planning, means, and history should be conducted at intake and periodically throughout treatment. Clinicians should be prepared to intervene actively when risk is identified, including safety planning, means restriction counseling, coordination with other providers, and, when necessary, higher levels of care.

Case conceptualization should explicitly incorporate the psychological effects of the compensation process itself. The distress experienced by a workers' compensation claimant is rarely reducible to the direct effects of injury; rather, it typically reflects the interaction of injury effects with the psychological demands of the claim process, financial stressors, workplace dynamics, and healthcare interactions. Formulations that neglect these system-level contributors will miss important therapeutic targets and may inadvertently pathologize responses to genuinely difficult circumstances.

Treatment planning should address multiple therapeutic targets. Evidence-based treatments for depression, anxiety, and post-traumatic stress are appropriate and effective for many workers' compensation claimants. Cognitive-behavioral approaches, in particular, can address the cognitive distortions that often accompany chronic injury and disability, including catastrophizing about pain, hopelessness about recovery, and helplessness in the face of system complexity. Pain-focused psychological interventions may be particularly valuable for the substantial subgroup of claimants with chronic pain. Trauma-focused treatments are appropriate for those with post-traumatic stress arising from the circumstances of injury or from adverse experiences within the compensation process.

Return-to-work support represents a specific therapeutic focus given the strong association between work status and psychological outcomes. Cullen et al. (2018), cited in Collie et al. (2020), documented the effectiveness of workplace interventions in return-to-work for musculoskeletal, pain-related, and mental health conditions. Psychologists can contribute to return-to-work efforts by addressing psychological barriers including anxiety about return, self-efficacy concerns, and workplace anxiety, and by collaborating with employers, return-to-work coordinators, and other providers to facilitate successful reintegration.

Advocacy for clients within the compensation system represents an important role for psychologists working with this population. This may include documenting the psychological impact of the injury and claim process, communicating with case managers and insurers

about treatment needs, and supporting clients in navigating administrative processes. Awareness of procedural justice considerations can inform advocacy efforts; helping clients feel that their voice is heard, that they understand the process, and that they are treated with respect can produce psychological benefits independent of specific claim outcomes.

Attention to the therapeutic relationship is particularly important given the interpersonal dynamics that often characterize compensation-related distress. Workers who have felt disbelieved, dismissed, or dehumanized in their interactions with employers, insurers, or other healthcare providers may bring these experiences into the therapy relationship. Establishing a genuinely supportive, non-judgmental therapeutic alliance, in which the client feels believed and respected, can itself be therapeutic. Clinicians should be mindful of their own reactions to the complexities of workers' compensation cases, avoiding both over-identification with the client's grievances and inadvertent skepticism that could mirror the client's negative experiences elsewhere.

Coordination with other providers is essential in this population. Workers' compensation claimants typically have multiple providers including primary care physicians, specialists, physical therapists, and, potentially, return-to-work coordinators. Effective care requires communication and coordination across this care team, ideally with the psychologist playing a role in ensuring that psychological considerations are integrated into overall care planning.

Awareness of iatrogenic effects is warranted. Psychologists should be aware that certain aspects of the compensation process, including some psychological evaluations conducted for administrative purposes, may themselves contribute to distress. Independent medical examinations, in particular, have been documented as sources of significant distress for claimants (Kilgour, Kosny, Akkermans, and Collie, 2015, cited in Collie et al., 2020). Psychologists conducting such evaluations should be attentive to procedural justice considerations and should conduct evaluations in ways that minimize additional harm.

Cultural competence considerations apply to work with this population. Injured workers span diverse cultural, linguistic, and socioeconomic backgrounds, and the experience of the compensation system may differ across these dimensions. Attention to how cultural factors shape the meaning of injury, help-seeking behavior, and interactions with system actors is essential.

Documentation practices deserve careful consideration. Records generated in the course of treatment may be requested by insurers, employers, or attorneys. Psychologists should document accurately and comprehensively while being mindful of how their documentation may be used in claim adjudication or dispute resolution processes.

Self-care for clinicians warrants attention. Working with workers' compensation claimants can be emotionally demanding, given the frequency of severe distress, chronic pain, and complex system dynamics. Clinicians should attend to their own wellbeing through supervision, peer support, and appropriate boundaries.

---

11. Future Directions and Research Gaps

The empirical literature on workers' compensation and mental health, while growing, contains substantial gaps that warrant attention in future research. Identifying these gaps is important both for guiding future investigation and for framing appropriate humility about the current state of knowledge.

Longitudinal research is particularly needed. The majority of studies in this area, including the large-scale investigation by Collie et al. (2020), are cross-sectional, limiting causal inference. Prospective cohort studies that follow workers from the time of injury through the trajectory of their compensation claim would provide much stronger evidence regarding the temporal sequence of injury, claim process, and psychological outcomes. Such studies could distinguish between distress that predates the claim, distress caused directly by the injury, and distress caused specifically by the claim process.

Research disentangling the effects of injury from the effects of the compensation process is a priority. Wadhwa et al. (2024) identified this as a key challenge in the current literature. Comparative studies of injured workers who do and do not enter the compensation system, matched on injury characteristics and other relevant variables, could help isolate the specific effects of the compensation process. However, such research is methodologically challenging given that workers with more severe injuries or greater work disability are more likely to enter the compensation system.

The role of pre-existing mental health conditions warrants further investigation. Both source documents note the possibility of reverse causation, whereby pre-existing psychological vulnerabilities may increase risk of both occupational injury and workers' compensation claims. Studies with detailed baseline assessment of mental health prior to injury would help clarify this relationship.

Cross-jurisdictional comparative research offers promising opportunities. Given the substantial variation in compensation system design across jurisdictions, comparative studies can help identify which system features produce better or worse psychological outcomes. Such research has both theoretical value in illuminating mechanisms and practical value in informing policy reform.

Intervention research is a substantial gap. While the literature has established the prevalence of psychological distress among claimants and identified predictors, relatively few studies have evaluated interventions designed to reduce this distress. Cullen et al. (2018), cited in Collie et al. (2020), reviewed workplace interventions for return-to-work, but comparable research on interventions targeting the compensation-mental health relationship specifically is limited. Randomized trials of screening programs, early intervention protocols, case management approaches, and system-level reforms are needed.

Research on specific subpopulations would enrich understanding. Emergency service workers, healthcare workers, migrant workers, and workers with pre-existing disabilities may face distinctive experiences within compensation systems, and dedicated research on these populations could inform tailored approaches. Kyron, Rikkers, O'Brien, and colleagues (2021), cited in Wadhwa et al. (2024), examined the experiences of police and emergency services employees with workers' compensation claims for mental health issues, exemplifying this focused approach.

The experiences of workers with mental health condition claims warrant more attention. While Collie et al. (2020) included a subgroup with mental health claims, comprehensive characterization of the compensation experience for these workers is limited. Given the growing recognition of psychological injuries as compensable conditions and the near-universal treatment access among these workers, understanding their trajectory is important.

Research on procedural justice and specific system reforms would be valuable. If procedural justice perceptions shape psychological outcomes, then interventions designed to enhance perceived fairness—including case manager training, communication protocols, and grievance procedures—should be tested empirically. Elbers et al. (2016), cited in both source documents, has begun this work through comparative research, but much remains to be done.

Qualitative research on claimant experiences continues to be needed. While quantitative research documents the association between compensation and distress, qualitative research can illuminate the meaning of these experiences, the specific mechanisms by which distress is generated, and the interventions that claimants themselves identify as helpful. The systematic review by Kilgour, Kosny, McKenzie, and Collie (2015), cited in Collie et al. (2020), demonstrated the value of qualitative synthesis, and continued qualitative research is warranted. Billias, MacEachen, and Sherifali (2023), cited in Wadhwa et al. (2024), examined precarious workers' responses when faced with procedural unfairness, exemplifying this approach.

Research on suicide and self-harm specifically merits expansion. Given the concerning findings from Applebaum et al. (2019) and Fishbain et al. (2009) documenting elevated suicide risk, additional research to characterize risk factors, identify high-risk subgroups, and evaluate preventive interventions is a priority.

Economic evaluation of interventions is important for policy implementation. Even effective interventions may not be adopted if their costs are prohibitive; research documenting the return on investment of screening, early intervention, and mental health treatment for injured workers could inform decisions by insurers and policymakers.

Research on the healthcare provider experience within compensation systems represents another gap. While studies have documented the effects of stressful interactions with healthcare providers on claimants, the perspective of healthcare providers themselves and the systemic factors that shape their interactions with injured workers warrants further attention. Brijnath et al. (2014) and Mazza et al. (2015), cited in Collie et al. (2020), have begun this work.

Finally, research on the lived experience of claimants, incorporating their voice in the design of interventions and reforms, is essential. Compensation systems have historically been

designed with limited input from the workers they are intended to serve. Participatory research approaches that center claimant perspectives could produce interventions that are more responsive to actual needs and preferences.

---

12. Conclusion

The evidence synthesized in this continuing education manual establishes that workers' compensation systems, despite their protective aims, are frequently associated with substantial psychological morbidity among the workers they are intended to serve. Prevalence rates of psychological distress among claimants substantially exceed those observed in the general working-age population, with more than four in ten workers with accepted claims reporting moderate or severe psychological distress (Collie et al., 2020). This distress spans the severity spectrum, from subclinical symptoms through severe depression and anxiety to elevated suicide risk documented in multiple studies (Wadhwa et al., 2024).

The predictors of psychological distress span multiple domains, including individual health status and pre-existing conditions, workplace responses to injury, features of the compensation process, and healthcare interactions. Among the most potent predictors are being off work, poor general health, low work ability, financial stress, stressful interactions with healthcare providers and workplace personnel, and diagnosed mental health conditions. These findings are consistent with the Sherbrooke model of work disability and support a conceptualization of psychological distress as arising from the interaction of injury with multiple system-level factors.

The mechanisms by which the compensation process contributes to psychological distress are multiple and interacting. They include the direct psychological impact of injury, the disruption of work identity and role, financial stress, adversarial interactions with insurers and case managers, procedural justice concerns, healthcare access barriers, and stigmatization. These mechanisms operate not sequentially but concurrently, producing a network of interacting effects that can be difficult to disentangle but that together account for the elevated psychological morbidity observed in this population.

The gap between the prevalence of psychological distress and the utilization of mental health services is particularly concerning. While workers with mental health condition claims typically access specialist mental health services, workers with musculoskeletal disorder claims and significant psychological distress often do not, with only about one in four such workers reporting mental health service utilization (Collie et al., 2020). This treatment gap represents a substantial unmet need and a clear target for intervention.

The clinical implications for psychologists are substantial. Working with workers' compensation claimants requires attention not only to the direct psychological effects of injury but also to the system-level factors that shape claimant experience. Comprehensive assessment, evidence-based treatment, effective coordination with other providers, and appropriate advocacy within the compensation system are all essential elements of effective practice with this population. Screening for the full spectrum of psychological outcomes, including suicidality, should be routine.

At the policy level, the findings support the case for reform of workers' compensation systems to better address the psychological needs of claimants. Screening programs for the early identification of workers experiencing or at risk of psychological distress could improve outcomes. Streamlined referral pathways to mental health services, particularly for workers with musculoskeletal disorders, could close the treatment gap. Case manager training and system design changes to enhance procedural justice could reduce the adverse psychological effects of the compensation process itself. Structural reforms to fund treatment for psychological conditions arising from compensable physical injuries could remove important barriers to care.

The state of the empirical literature, while informative, contains substantial gaps. Longitudinal research to establish causal relationships, cross-jurisdictional comparative research to identify beneficial system features, intervention research to evaluate strategies for improving outcomes, and research on specific subpopulations and lived experiences all warrant priority.

The paradox at the heart of the workers' compensation system—that a system designed to help injured workers may in fact contribute to their psychological harm—demands attention from psychologists, policymakers, employers, insurers, and the workers themselves. Resolving this paradox requires recognition that compensation is not merely an administrative process but a psychological experience with meaningful implications for mental health. When compensation systems are designed and implemented in ways that align with psychological

principles—that respect worker dignity, ensure procedural fairness, minimize administrative burden, and integrate mental health considerations into care—they have the potential to fulfill their protective aims. When they fail to attend to these considerations, they risk producing the very harms they were designed to prevent.

The role of psychologists in this landscape is multiple and important. As clinicians, psychologists can provide effective treatment to injured workers experiencing psychological distress. As researchers, psychologists can generate the evidence needed to guide reform. As advocates, psychologists can promote system-level changes that align compensation practices with mental health principles. And as consultants to employers, insurers, and policymakers, psychologists can shape the design of compensation systems to better serve the workers they exist to protect. In each of these roles, the aim is the same: to ensure that when workers are harmed in the course of their labor, the systems that exist to support them do so effectively, without adding to the burden of injury the additional weight of psychological distress.

---

13. References

Applebaum, K. M., Asfaw, A., O'Leary, P. K., Busey, A., Tregear, S. J., & Dowd, K. (2019). Suicide and drug-related mortality following occupational injury. *American Journal of Industrial Medicine*, *62*(9), 733–741.

Asfaw, A. G., Bushnell, P. T., & Ray, T. K. (2010). Relationship of work injury severity to family member hospitalization. *American Journal of Industrial Medicine*, *53*(5), 506–513.

Asfaw, A. P., & Souza, K. P. (2012). Incidence and cost of depression after occupational injury. *Journal of Occupational and Environmental Medicine*, *54*(9), 1086–1091.

Barr, B., Taylor-Robinson, D., Stuckler, D., Loopstra, R., Reeves, A., & Whitehead, M. (2016). 'First, do no harm': Are disability assessments associated with adverse trends in mental health? A longitudinal ecological study. *Journal of Epidemiology and Community Health*, *70*(4), 339–345.

Betters, C. J., & Shaw, L. R. (2009). Establishing predictor variables for unmet psychological need in the Florida workers' compensation system. *Work*, *32*(2), 145–154.

Billias, N., MacEachen, E., & Sherifali, S. (2023). "I grabbed my stuff and walked out": Precarious workers' responses and next steps when faced with procedural unfairness during work injury and claims process. *Journal of Occupational Rehabilitation*, *33*(1), 160–169.

Brijnath, B., Mazza, D., Singh, N., Kosny, A., Ruseckaite, R., & Collie, A. (2014). Mental health claims management and return to work: Qualitative insights from Melbourne, Australia. *Journal of Occupational Rehabilitation*, *24*(4), 766–776.

Calvey, J., & Jansz, J. (2005). Women's experience of the workers compensation system. *Australian Journal of Social Issues*, *40*(2), 285–311.

Carnide, N., Franche, R. L., Hogg-Johnson, S., Cote, P., Breslin, C., Severin, C. N., Bultmann, U., & Krause, N. (2016). Course of depressive symptoms following a workplace injury: A 12-month follow-up update. *Journal of Occupational Rehabilitation*, *26*(2), 204–215.

Collie, A., Lane, T. J., Hassani-Mahmooei, B., Thompson, J., & McLeod, C. (2016). Does time off work after injury vary by jurisdiction? A comparative study of eight Australian workers' compensation systems. *BMJ Open*, *6*(5), e010910.

Collie, A., Sheehan, L., Lane, T. J., & Iles, R. (2020). Psychological distress in workers' compensation claimants: Prevalence, predictors and mental health service use. *Journal of Occupational Rehabilitation*, *30*(2), 194–202.

Craig, A., Tran, Y., Guest, R., Gopinath, B., Jagnoor, J., Bryant, R. A., Collie, A., Tate, R., Kenardy, J., Middleton, J. W., & Cameron, I. (2016). Psychological impact of injuries sustained in motor vehicle crashes: Systematic review and meta-analysis. *BMJ Open*, *6*(9), e011993.

Cullen, K. L., Irvin, E., Collie, A., Clay, F., Gensby, U., Jennings, P. A., Hogg-Johnson, S., Kristman, V., Laberge, M., McKenzie, D., Newnam, S., Palagyi, A., Ruseckaite, R., Sheppard, D. M., Shourie, S., Steenstra, I., Van Eerd, D., & Amick, B. C. (2018). Effectiveness of workplace interventions in return-to-work for musculoskeletal, pain-related and mental health conditions: An update of the evidence and messages for practitioners. *Journal of Occupational Rehabilitation*, *28*(1), 1–15.

Dawson, S. E. (1994). Workers' compensation in Pennsylvania: The effects of delayed contested cases. *Journal of Health & Social Policy*, *6*(1), 87–100.

Dersh, J., Gatchel, R. J., Mayer, T., Polatin, P., & Temple, O. R. (2006). Prevalence of psychiatric disorders in patients with chronic disabling occupational spinal disorders. *Spine*, *31*(10), 1156–1162.

Eggert, S. (2010). Psychosocial factors affecting employees' abilities to return to work. *American Association of Occupational Health Nurses Journal*, *58*(2), 51–55.

Elbers, N. A., Collie, A., Hogg-Johnson, S., Lippel, K., Lockwood, K., & Cameron, I. D. (2016). Differences in perceived fairness and health outcomes in two injury compensation systems: A comparative study. *BMC Public Health*, *16*, 658.

Fishbain, D. A., Bruns, D., Disorbio, J. M., & Lewis, J. E. (2009). Risk for five forms of suicidality in acute pain patients and chronic pain patients vs pain-free community controls. *Pain Medicine*, *10*(6), 1095–1105.

Franche, R. L., Carnide, N., Hogg-Johnson, S., Cote, P., Breslin, C., Bultmann, U., Severin, C. N., & Krause, N. (2009). Course, diagnosis and treatment of depressive symptomatology in workers following a workplace injury: A prospective cohort study. *Canadian Journal of Psychiatry*, *54*(8), 534–546.

Gabbe, B. J., Cameron, P. A., Williamson, O. D., Edwards, E. R., Graves, S. E., & Richardson, M. D. (2007). The relationship between compensable status and long-term patient outcomes following orthopaedic trauma. *Medical Journal of Australia*, *187*(1), 14–17.

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.

Greenough, C. G., & Fraser, R. D. (1989). The effects of compensation on recovery from low-back injury. *Spine*, *14*(9), 947–955.

Guest, G. H., & Drummond, P. D. (1992). Effect of compensation on emotional state and disability in chronic back pain. *Pain*, *48*(2), 125–130.

Hee, H. T., Whitecloud, T. S., Myers, L., Roesch, W., & Ricciardi, J. E. (2001). SF-36 health status of workers compensation cases with spinal disorders. *The Spine Journal*, *1*(3), 176–182.

Hepburn, C. G., Kelloway, E. K., & Franche, R. L. (2010). Early employer response to workplace injury: What injured workers perceive as fair and why these perceptions matter. *Journal of Occupational Health Psychology*, *15*(4), 409–420.

Himmelstein, J. S., Feuerstein, M., Stanek, E. J., Koyamatsu, K., Pransky, G. S., Morgan, W., & Anderson, K. O. (1995). Work-related upper-extremity disorders and work disability: Clinical and psychosocial presentation. *Journal of Occupational and Environmental Medicine*, *37*(11), 1278–1286.

Ioannou, L., Braaf, S., Cameron, P., Gibson, S. J., Ponsford, J., Jennings, P. A., Arnold, C. A., Georgiou-Karistianis, N., & Giummarra, M. J. (2016). Compensation system experience at 12 months after road or workplace injury in Victoria, Australia. *Psychological Injury and Law*, *9*(4), 376–389.

Keogh, J. P., Nuwayhid, I., Gordon, J. L., & Gucer, P. W. (2000). The impact of occupational injury on injured worker and family: Outcomes of upper extremity cumulative trauma disorders in Maryland workers. *American Journal of Industrial Medicine*, *38*(5), 498–506.

Kessler, R. C., Andrews, G., Colpe, L. J., Hiripi, E., Mroczek, D. K., Normand, S. L., Walters, E. E., & Zaslavsky, A. M. (2002). Short screening scales to monitor population prevalences and trends in non-specific psychological distress. *Psychological Medicine*, *32*(6), 959–976.

Kessler, R. C., Barker, P. R., Colpe, L. J., Epstein, J. F., Gfroerer, J. C., Hiripi, E., Howes, M. J., Normand, S. L., Manderscheid, R. W., Walters, E. E., & Zaslavsky, A. M. (2003). Screening for serious mental illness in the general population. *Archives of General Psychiatry*, *60*(2), 184–189.

Kilgour, E., Kosny, A., Akkermans, A. J., & Collie, A. (2015). Procedural justice and the use of independent medical evaluations in workers' compensation. *Psychological Injury and Law*, *8*(2), 153–168.

Kilgour, E., Kosny, A., McKenzie, D., & Collie, A. (2015a). Healing or harming? Healthcare provider interactions with injured workers and insurers in workers' compensation systems.

Journal of Occupational Rehabilitation, *25*(1), 220–239.

Kilgour, E., Kosny, A., McKenzie, D., & Collie, A. (2015b). Interactions between injured workers and insurers in workers' compensation systems: A systematic review of qualitative research literature. *Journal of Occupational Rehabilitation*, *25*(1), 160–181.

Kim, J. (2013). Depression as a psychosocial consequence of occupational injury in the US working population: Findings from the medical expenditure panel survey. *BMC Public Health*, *13*, 303.

King, T. L., Disney, G., Sutherland, G., Kavanagh, A., Aitken, Z., LaMontagne, A. D., Milner, A., & Spittal, M. J. (2023). Associations between workers' compensation and self-harm: A retrospective case-series study of hospital admissions data. *The Lancet Regional Health – Western Pacific*, *30*, 100614.

Kyron, M. J., Rikkers, W., O'Brien, P., Bartlett, J., & Lawrence, D. (2021). Experiences of police and emergency services employees with workers' compensation claims for mental health issues. *Journal of Occupational Rehabilitation*, *31*(1), 197–206.

Lippel, K. (1999). Workers' compensation and stress: Gender and access to compensation. *International Journal of Law and Psychiatry*, *22*(1), 79–89.

Lippel, K. (2007). Workers describe the effect of the workers' compensation process on their health: A Quebec study. *International Journal of Law and Psychiatry*, *30*(4-5), 427–443.

Lopez Gomez, M. A., Williams, J. A. R., Boden, L., Sorensen, G., & Hopcia, K. (2020). The relationship of occupational injury and use of mental health care. *Journal of Safety Research*, *74*, 227–232.

Macpherson, R. A., Lane, T. J., Collie, A., & McLeod, C. B. (2018). Age, sex, and the changing disability burden of compensated work-related musculoskeletal disorders in Canada and Australia. *BMC Public Health*, *18*(1), 758.

Mazza, D., Brijnath, B., Singh, N., Kosny, A., Ruseckaite, R., & Collie, A. (2015). General practitioners and sickness certification for injury in Australia. *BMC Family Practice*, *16*, 100.

Mongeau, S., Lightfoot, N., MacEwan, L., Larivière, C., & Kosny, A. (2021). Union, employer and compensation system gaps and failures: Workers with injuries perceptions. *Work*, *69*(2), 485–495.

Morse, T. F., Dillon, C., Warren, N., Levenstein, C., & Warren, A. (1998). The economic and social consequences of work-related musculoskeletal disorders: The Connecticut Upper-Extremity Surveillance Project (CUSP). *International Journal of Occupational and Environmental Health*, *4*(4), 209–216.

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. *Journal of Clinical Psychiatry*, *76*(8), e1000–e1005.

Orchard, C., Carnide, N., & Smith, P. (2020). How does perceived fairness in the workers' compensation claims process affect mental health following a workplace injury? *Journal of Occupational Rehabilitation*, *30*(1), 40–48.

Orchard, C., Carnide, N., Smith, P., & Mustard, C. (2021). The association between case manager interactions and serious mental illness following a physical workplace injury or illness: A cross-sectional analysis of workers' compensation claimants in Ontario. *Journal of Occupational Rehabilitation*, *31*(4), 895–902.

Pollard, W. M. (2014). Injured teachers' experiences of the Victorian workers' compensation stress claims process: Adversarial and alienating. *Health Sociology Review*, *23*(2), 102–112.

Prawitz, A. D., Garman, E. T., Sorhaindo, B., O'Neill, B., Jinhee, K., & Drentea, P. (2006). InCharge Financial Distress/Financial Well-Being Scale: Development, administration, and score interpretation. *Journal of Financial Counseling and Planning*, *17*(1), 34–50.

Prochaska, J. J., Sung, H. Y., Max, W., Shi, Y., & Ong, M. (2012). Validity study of the K6 scale as a measure of moderate mental distress based on mental health treatment need and utilization. *International Journal of Methods in Psychiatric Research*, *21*(2), 88–97.

Reid, J., Ewan, C., & Lowy, E. (1991). Pilgrimage of pain: The illness experiences of women with repetition strain injury and the search for credibility. *Social Science & Medicine*, *32*(5), 601–612.

Roberts-Yates, C. (2003). The concerns and issues of injured workers in relation to claims/injury management and rehabilitation: The need for new operational frameworks. *Disability and Rehabilitation*, *25*(16), 898–907.

Smith, P. M., Black, O., Keegel, T., & Collie, A. (2014). Are the predictors of work absence following a work-related injury similar for musculoskeletal and mental health claims? *Journal of Occupational Rehabilitation*, *24*(1), 79–88.

Spittal, M. J., Grant, G., O'Donnell, M., McFarlane, A. C., & Studdert, D. M. (2019). Development of prediction models of stress and long-term disability among claimants to injury compensation systems: A cohort study. *BMJ Open*, *8*(4), e020803.

Strunin, L., & Boden, L. I. (2004). The workers' compensation system: Worker friend or foe? *American Journal of Industrial Medicine*, *45*(4), 338–345.

Wadhwa, S., Taouk, Y., Spittal, M. J., & King, T. (2024). Workplace injury compensation and mental health and self-harm outcomes: A systematic review. *NEW SOLUTIONS: A Journal of Environmental and Occupational Health Policy*, *34*(2), 71–82.

Wagner, E. R., Woodmass, J. M., Chang, M. J., Welp, K. M., Higgins, L. D., & Warner, J. J. P. (2020). The impact of workers' compensation on recovery after biceps tenodesis. *Journal of Shoulder and Elbow Surgery*, *29*(9), 1783–1788.

Wall, C. L., Morrissey, S. A., & Ogloff, J. R. P. (2008). Personality traits, psychological health, and the workers' compensation system. *Australian Journal of Rehabilitation Counselling*, *14*(2), 55–68.