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Workplace bullying and well-being in crisis-affected healthcare organizations: Status vulnerability evidence from Lebanon

Abstract

Purpose: This study examines workplace bullying and psychosocial well-being among healthcare professionals working in crisis-affected organizations. It contributes to behavioral health scholarship by theorizing bullying as a chronic organizational stressor that is amplified under conditions of institutional fragility and unequal protection.

Design/methodology/approach: Drawing on survey data from 411 healthcare professionals in Lebanon, a country marked by political instability, economic collapse, and overlapping crises, the study analyses workplace bullying exposure across gender and status-based demographic categories using the Negative Acts Questionnaire-Revised (NAQ-R).

Findings: The results show no significant gender effects, but higher bullying exposure among younger employees, widowed participants, residents, and those with university degrees. Gossip and rumors and excessive workload were the most prevalent bullying behaviors, while physical intimidation was rare.

Originality: The study advances workplace bullying scholarship by extending bullying frameworks into fragile and crisis-affected contexts and by introducing an intersectional status vulnerability model that foregrounds social stigma (e.g., widowhood) and professional dependency (e.g., residents' reliance on supervisors). It further shows that symbolic and structural forms of domination (e.g., overload, monitoring, and reputational harm) predominate over physical intimidation in crisis-affected healthcare settings.

Practical implications: The findings highlight the need for targeted organizational interventions to identify and protect vulnerable occupational groups such as residents within crisis-affected healthcare systems. Strengthening anti-bullying policies, supervisory accountability, and confidential reporting mechanisms can help mitigate psychosocial harm and support employee well-being under conditions of institutional strain.

Keywords: workplace bullying; healthcare; crisis; organizational vulnerability; well-being

Introduction

Workplace bullying has well-documented psychological consequences including anxiety, burnout, sleep disorders, and depression, often leading to diminished organizational citizenship and higher turnover. These effects are exacerbated in crisis contexts where collective trauma interacts with workplace stressors (Nielsen & Einarsen, 2018). Existing research on workplace bullying often assumes that gender is the primary axis of vulnerability. Such an assumption neglects the social and institutional hierarchies that produce unequal exposure to bullying behaviors. In fragile contexts, where economic collapse, political instability, and institutional

decay converge, bullying is not only interpersonal but also an organizational manifestation of structural violence (Salin, 2021).

The following paper addresses this theoretical blind spot by examining how intersecting social and professional demographics shape the experience of bullying in Lebanon's healthcare sector during periods of national crisis. Workplace bullying has been widely documented in healthcare and nursing contexts, where hierarchical work structures, role dependency, high workload, and intense emotional labor can normalize patterns of persistent mistreatment (Lever et al., 2019). Johnson's (2009) international review highlights that bullying in nursing cannot be reduced to interpersonal friction alone, but is often embedded in organizational routines and power relations that shape who becomes exposed to hostility and how such experiences are handled, silenced, or normalized (Johnson, 2009; Camgoz et al, 2024). Consistent with this, Ariza-Montes et al. (2013) show that bullying among healthcare workers is both prevalent and consequential, with implications for well-being and the sustainability of healthcare workforces.

Any individual, irrespective of gender, race, sexual orientation, age and other social background can easily become a target (Salin, 2021). Bullying causes social, physical, psychological, psychosomatic, and psychiatric problems in the workforce (Leymann, 1990). Research shows that one-third of nurses intend to leave their current jobs due to workplace bullying (Al Muharraq et al., 2022).

From an organizational perspective, bullying is not only a behavioral issue but also a governance and accountability concern (Fowler, 2025), as it reflects how institutions allocate workload, regulate supervisory discretion, and protect voice and dignity at work. These issues

become more salient in crisis-affected organizations, where weakened safeguards and intensified pressures can normalize mistreatment while limiting employees' capacity to resist or report harm. Examining bullying patterns under crisis, therefore, offers not only descriptive insight but also a basis for organizational intervention that is structurally grounded rather than individually moralized.

Well-being is a necessary occupational strength, because it is correlated to employee productivity, performance, and safety behavior (Demerouti et al., 2019). Thus, well-being is a core organizational outcome, closely linked to performance, safety, and sustainability in healthcare workplaces. The purpose of the study is to interrogate the prevalence of workplace bullying along with comparison with demographic characteristics in a descriptive study among healthcare employees in a medical center in Lebanon. This offers context-sensitive evidence to inform organizational interventions aimed at strengthening dignity, protection, and well-being at work.

This study contributes theoretically by advancing a crisis-sensitive organizational account of workplace bullying and well-being. In crisis-affected healthcare systems, bullying becomes more than deviant interpersonal conduct: it is sustained through organizational conditions that heighten dependence on authority, reduce credibility and protection for vulnerable groups, and normalize control and everyday domination. The paper extends workplace bullying frameworks by conceptualizing crisis as a structural amplifier of organizational stress and psychosocial harm, and by introducing an intersectional status vulnerability model that highlights how social stigma (e.g., widowhood) and professional dependency (e.g., residents' reliance on supervisors) shape

exposure to bullying more than gender alone. Healthcare hierarchies are particularly pronounced in residency training systems, where trainees occupy structurally dependent positions that may increase exposure to workplace mistreatment.

The paper proceeds as follows. First, we outline the conceptual framing that positions workplace bullying as a crisis-amplified organizational stress process shaped by hierarchical dependence and status vulnerability. We then present the methods and findings, followed by a discussion that links bullying exposure to well-being harm and derives organizational-level and individual-level implications grounded in the results.

A crisis-sensitive organizational vulnerability perspective on workplace bullying

The concept of workplace bullying was introduced in the 1970s by Carol Brodsky (1976) and later developed further by Heinz Leymann (1990). Leymann introduced the Work Environment Hypothesis, which emphasizes the work context and how it can trigger the potential for bullying (Leymann, 1990). Workplace bullying in healthcare settings is often approached as an individual or interpersonal phenomenon, yet such framings can understate how organizational conditions structure exposure to mistreatment. In crisis-affected environments, institutional fragility, heightened dependency on hierarchical relations, and weakened protective infrastructures can intensify vulnerability and normalize everyday forms of bullying that directly undermine well-being. Workplace bullying is a complicated social phenomenon that involves multiple causal components that can be explained at different levels, depending on whether we focus on the actor's behavior or the target's perceptions, feelings, and responses (Einarsen et al., 2020).

Workplace bullying refers to recurrent negative acts directed at employees who experiences difficulty defending themselves, resulting in humiliation, distress, and impaired work functioning (Einarsen & Raknes, 1997; Einarsen et al., 2020). Foundational scholarship has shown that bullying is not simply a matter of interpersonal deviance, but is often embedded in organizational conditions such as leadership practices, work design, and unequal power relations (Leymann, 1996). This organizational emphasis is particularly important in healthcare settings where professional dependency, hierarchical authority, and high workload pressures can intensify exposure to bullying behaviors and constrain targets' capacity to respond.

This paper extends behavioral health theory by integrating the ecological model of workplace stress with intersectionality. It highlights how macro-level crises (economic collapse, trauma exposure) shape and sustain micro-level experiences of bullying and perceived well-being. We therefore conceptualize bullying as a crisis-amplified organizational stress process in which institutional fragility and hierarchical dependence shape patterned exposure, producing unequal well-being harm for status-vulnerable groups. Although workplace bullying research draws on multiple theoretical traditions rather than a single unified model, prior scholarship has generated robust frameworks for understanding how individual, organizational, and societal conditions interact to shape exposure to and consequences of bullying. This nature of the field supports the claim that applied disciplines frequently focus on specific aspects of the issue rather than developing a holistic, guiding theory (Branch et al., 2021). Instead of a single theory, research on workplace bullying and its effects over the years has yielded significant theoretical and applied insights. A multifaceted ecological framework is well-suited to capture the various

ways in which people, organizations, and societal systems interact to initiate and sustain bullying in the workplace (Branch et al., 2021).

This study uses an intersectional analytical lens to examine how social and professional status positions (e.g., widowhood and residents' professional dependency) shape bullying exposure and psychosocial well-being within a crisis-affected organizational context. This highlights that bullying in crisis contexts is not randomly distributed, but clustered around positions of heightened dependence and reduced protection within organizational hierarchies. The intersectional approach gives voice to a wider spectrum of groups and subgroups situated at different intersecting points, while avoiding oversimplified, essentializing, and generalizing criticisms of workplace bullying (McBride et al., 2015).

The manifestation and escalation of workplace bullying are influenced by both individual and group traits and the work environment. Consequently, bullying has an unfavorable impact on individuals, groups, work environment, and organizational culture. Thus, this either discourages or, more likely, endorses further bullying. The framework effectively draws attention to the complexity of workplace bullying in understanding why responses that focus exclusively on one level—for example, the target, the perpetrator, or the interactions between the two—will be unsuccessful in resolving the relevant conflict and reducing the probability of bullying incidents in the future (Branch et al., 2013). The concept of "selective incivility" symbolizes contemporary discriminatory practices, wherein women and members of ethnic minorities are disproportionately exposed to subtle negative social behaviors. Selective incivility allows perpetrators to cover their discriminatory views and present themselves as non-sexist (or non-

racist), whereas women and members of other marginalized social groups may experience subtle but systematic forms of interpersonal prejudice (Cortina, 2008).

This framing suggests that bullying exposure and well-being harm are best understood as organizationally patterned outcomes shaped by vulnerability and dependence, an issue that becomes particularly salient in crisis-affected healthcare systems where institutional safeguards may be weakened.

Workplace bullying under crisis: why the Lebanese healthcare context matters

Lebanon represents a crisis-affected organizational environment in which healthcare institutions have operated under prolonged instability, resource scarcity, and systemic strain. In such contexts, organizational safeguards that typically limit mistreatment may be weakened, while hierarchical dependency and workload intensification become normalized, creating conditions in which bullying behaviors can be more difficult to contest and more damaging to well-being.

While workplace bullying has been examined across multiple organizational settings, comparatively less attention has been paid to how crisis conditions reshape bullying exposure, reporting capacity, and psychosocial harm among healthcare professionals (Morales Palomares et al., 2025). In crisis-affected environments, resource scarcity, institutional fragility, and heightened dependency on organizational hierarchies may weaken protective infrastructures and intensify vulnerability (Özbilgin, Erbil, & Valsecchi, 2025; Tekeste & Özbilgin, 2026), producing a context in which bullying becomes more difficult to challenge and more damaging to well-being. This concern is consistent with research showing that economic crisis conditions

can deepen insecurity and strain organizational support, with uneven consequences for workers' lived experiences (Georganta et al., 2025).

Workplace bullying is a global problem and a mounting concern in crisis settings such as Lebanon (Alameddine et al., 2017; León-Pérez et al., 2021). Crises contexts are particularly interesting as sites of workplace bullying as priorities shift and workplace bullying may remain uncontested and naturalized. As a context of crises, Lebanon has faced a lot of crises since the civil war that continued from 1975 until 1990 with the consequent inflow of Palestinian and Syrian refugees. More than 1.5 million Syrian refugees have sought refuge in the country since 2011, making it the country with the greatest refugee population per capita in the world, despite its ongoing economic crisis (United Nations, 2022). This explains how the context of a country and state, how the context of vulnerability and crises shapes how bullying is experienced.

One of the largest explosions in the history of Beirut occurred on August 4, 2020. The blast severely damaged Lebanon's healthcare infrastructure and caused 6,000 injuries and more than 220 fatalities. Around 500 hospital bed equivalents were damaged and there were many people in need of medical care because of how urgent the situation was (Georges et al., 2021). The economy was significantly impacted by the banking sector's destruction of life savings as wealthy and politically connected people withdrew their money out of Lebanon (United Nations, 2022).

Importantly, bullying in such contexts should not be understood merely as an individual-level experience, but as a patterned organizational outcome shaped by relations of voice, recognition, and protection. Recent scholarship on organizational harm under conditions of weak institutional safeguards further suggests that mistreatment may be sustained through muted

grievance channels and constrained agency, particularly for vulnerable groups occupying dependent or marginal positions within organizational hierarchies. Against this backdrop, the present study contributes by examining workplace bullying and well-being among healthcare professionals in Lebanon, offering crisis-sensitive organizational evidence on how bullying behaviors cluster and how exposure relates to unequal vulnerability within disrupted healthcare work systems.

Against this backdrop, we examine workplace bullying exposure and psychosocial well-being among healthcare professionals in Lebanon to clarify how crisis conditions shape patterned vulnerability across organizational and status positions.

Methods

Study Design

This study used a descriptive cross-sectional design to identify the prevalence of workplace bullying and its association with employees' demographic variables. The survey was self-reported by the participants. All residents, nurses, and administrative employees with valid email addresses for the survey received emails regarding the study. A weekly reminder was sent for a month. The names of the research members, their phone numbers and email addresses, and the approval of the Ethical Committee were mentioned in the email. The email contained a link to the online survey.

Participants

The inclusion criteria were female or male healthcare employees aged 18 years and above, irrespective of ethnicity, job position or work position (full-time or part-time). The elimination criteria for the objective samples were individuals under 18 years old (e.g., students or volunteers). Occupational categories included physicians in residency training (residents), nurses, and administrative healthcare staff. In the analysis, comparisons between residents and other groups refer to the contrast between physicians undergoing residency training and all other healthcare professionals in the sample. Individuals who have retired or have not had a job for the previous 12 months were disqualified and excluded from the study. As for the number of healthcare employees, there were 1,200 in 2021, with a response rate of 34.25%.

Measurements

The Negative Acts Questionnaire-Revised (NAQ-R) was a self-administered questionnaire with closed-ended questions that captured demographic and professional characteristics, as well as exposure to workplace bullying during the past six months, consistent with the NAQ-R reference period. (Einarsen et al., 2009; Rosander et al., 2024). The 5-Point Likert Scale includes: never, occasionally, monthly, weekly, and daily. It contains three dimensions: seven items for work-related bullying, 12 for personal bullying, and three for physically intimidating bullying.

Data Collection and Analysis

The study was approved by the university's Ethics Committee in September 2021. Data analysis was done by SPSS (IBM SPSS, version 28.0). Independent variables that remained statistically

significant were kept in the final models, and a confidence interval (CI) = 95% and a p-value < 0.05 were adopted.

Results

This section presents the empirical findings in a structured manner. We first report measurement reliability for the bullying dimensions used in the analysis. We then summaries descriptive patterns of exposure to bullying behaviors across the sample, followed by inferential analyses examining group differences and associations with key demographic and work-related characteristics. Throughout, we prioritize synthesizing the main empirical patterns rather than repeating tabulated values, with tables provided to support transparency and allow detailed inspection of the full results.

The independent variables are gender (females and males), age (grouped into four categories as follows: Group 1 = 1957-1967, Group 2 = 1968-1978, Group 3 = 1979-1989, Group 4 = 1990-2001), relationship status (grouped into five categories as follows: Group 1 = Single, Group 2 = In a relationship, Group 3 = Married, Group 4 = Divorced, and Group 5 = Widowed), type of profession (grouped into three categories as follows: Group 1 = Administrative, Group 2 = Resident and Group 3 = Nurse), years of experience (grouped into four categories as follows: Group 1 = Less than five years, Group 2 = Between 5 and 10 years, Group 3 = Between 11 and 20 years and Group 4 = More than 20 years) and education level (grouped into three categories as follows: Group 1 = Middle school, Group 2 = High school and Group 3 = University). By middle school (up to 9th grade), while high school means up to the 12th grade.

Table 1: Demographic characteristics of the employees (N = 411)

Gender	**Frequency (%)**
Females	303 (73.7)
Males	108 (26.3)
Year of Birth	
1957-1967	51 (12.4)
1968-1978	83 (20.2)
1979-1989	95 (23.1)
1990-2001	182 (44.3)
Relationship Status	
Single	195 (47.4)
In a Relationship	194 (47.2)
Married	6 (1.5)

Divorced	3 (0.7)
Widowed	13 (3.2)
Education Level	
Middle School	44 (10.7)
High School	78 (19.0)
University	289 (70.3)
Type of Profession	
Administrative	67 (16.3)
Resident	33 (8.0)
Nurse	311 (75.7)
Years of Experience	
Less than 5 years	123 (29.9)

5-10 years	86 (20.9)
11-20 years	107 (26.0)

Cronbach's Alpha value was applied to check the internal consistency of the elements present in the questionnaire. The value for the 22 items overall is 0.921. The value is 0.863 for personal bullying, 0.828 for work-related bullying, and 0.558 for physically intimidating bullying. Table 1 demonstrates the demographic information for the participants. The number of female participants is 303 (73.7%), while the number of male participants is 108 (26.3%). Those born between 1990 and 2001 had the highest number (n = 182, 44.3%), followed by those born between 1957 and 1967 (n = 51, 12.4%). Most were single (n = 195, 47.4%) or in a relationship (n = 194, 47.2%), compared with those who were divorced (n = 3, 3.2%). Most participants had university degrees (n = 289, 70.3%). The years of experience were comparable among the different groups. Internal consistency was acceptable for the overall bullying measure and the work-related and person-related bullying subscales. However, the physically intimidating bullying subscale demonstrated comparatively lower internal consistency ($\alpha = 0.558$).

We interpret this dimension with caution for two reasons. First, physically intimidating behaviors are typically less frequently reported than work-related or person-related bullying, which can reduce covariance between items and lower reliability estimates. Second, the small number of items within short subscales can produce more unstable alpha values. Accordingly, results relating to physically intimidating bullying are treated as indicative rather than definitive, and the primary empirical interpretation of bullying in this study is grounded in the more robust patterns observed for work-related and person-related bullying behaviors.

Table 2 presents the means and standard deviations (SD) for each negative act across the whole sample (n = 411) for the instrument prepared by Ståle Einarsen. The SD values for all items were less than 1, indicating that the participants' measurements were close to the mean.

Table 2: Mean and SD of each item in Einarsen's total 22 scale used for consistency (N = 411)

#	Negative behaviors	Mean	SD
1	Someone concealed or hidden information that could affect your performance.	1.56	0.946
2	Being exposed to humiliation and mockery about things related to your work.	1.49	0.898
3	Being instructed to perform some work that is below your proficiency.	1.68	1.070
4	Your main duties are being removed or replaced with other silly or uncomfortable ones.	1.63	0.985
5	Spreading gossips and rumors about you.	1.80	1.049
6	Being ignored or excluded (sent to exile).	1.31	0.710

7	Issuing some humiliating remarks that offend you (i.e., related to your habits and cultural background), behaviors or your private life.	1.36	0.779
8	Being shouted at or being a victim of spontaneous anger (or outrage).	1.72	0.950
9	Being exposed to intimidating behavior or terrorization such as finger-pointing, interference to the private space, pushing, preventing/blocking the way.	1.18	0.563
10	Other persons give you a hint or gesture that you should quit your job.	1.22	0.658
11	Keep reminding you of your mistakes and errors related to your work.	1.43	0.693
12	Being ignored or exposed to an aggressive reaction when you trying to approach.	1.34	0.743
13	Being criticized frequently about your work and efforts.	1.55	0.897
14	Your opinions and point of views are being ignored.	1.63	0.908

15	Being exposed to practical jokes (which are silly jokes or pranks meant to show you as a foolish person to entertain others) by others that you don't get along with.	1.27	0.638
16	Giving you tasks with unrealistic or impossible targets or due dates.	1.29	0.668
17	Direct some accusation and allegation against you.	1.28	0.620
18	Watching or monitoring your work excessively (over-limit).	1.47	0.892
19	Being subject to pressure not to claim your entitlements (such as sick leave, or holiday, or travel expenses).	1.45	0.905
20	Being subject to teasing and mockery excessively (over-limit).	1.13	0.446
21	Being exposed to overload of work (much of work) that cannot be managed or controlled.	1.80	1.037
22	Being threatened with violence or physical abuse or actual assault.	1.07	0.346

The items with the highest mean are: "Spreading gossips and rumors about you" and "Being exposed to an overload of work (much of work) that cannot be managed or controlled", both with a mean of 1.80. The second highest item with a mean = 1.72 is "Being shouted at or being a victim of spontaneous anger (or outrage)). The third item with the highest mean is "Being instructed to perform some work that is below your proficiency" (mean = 1.68). As for the items

with the lowest mean, the first item is “Being threatened with violence or physical abuse or actual assault”, (mean = 1.07), followed by “Being subject to teasing and mockery excessively (over-limit)”, (mean = 1.13), and lastly “Being exposed to intimidating behavior or terrorization such as finger-pointing, interference to the private space, pushing, preventing/blocking the way” (mean = 1.18).

The two negative acts with the highest frequency that happened on a daily basis are “Watching or monitoring your work excessively (over-limit)” (n = 22), followed by “Spreading gossips and rumors about you” (n = 20). This shows that excessive monitoring of their work and spreading rumors are the most common forms of bullying experienced daily. As for physical violence, this negative act, “Being threatened with violence or physical abuse or actual assault” is the least common happening on a daily basis (n = 1), implying that physical abuse is not common in the medical center.

In the first part of the analysis, bullying is analyzed using means and SDs, since the total bullying score is presented as continuous data. In the second part, each bullying subtype is analyzed according to the three cut-off points described by Einarsen. The Independent T-test is implemented to compare means between two groups, which are gender (treated as a binary group) and the sum of total bullying, but the results are not significant. There is no significant difference between the means of total bullying and gender (p = 0.537), and between the means of total bullying and years of experience (p = 0.450). Table 3 shows the summary of the one-way analysis of variance (ANOVA) to compare three groups or more (for the rest of the five variables);

where total bullying was well-defined as the sum (22 items) of all work-related, personal, and physically intimidating bullying and named so for abbreviation purposes.

Table 3: Summary of the tests for the four types of bullying

	Total sum of bullying	**Personal bullying**	**Work-related bullying**	**Physically intimidating bullying**
Gender	Not significant	Not significant	Not significant	Not significant
Year of birth categories	Significant ($p = 0.021$)	Not significant	Significant ($p = 0.002$)	Significant ($p = 0.041$)
Type of profession	Significant ($p < 0.001$)	Significant ($p < 0.001$)	Significant ($p < 0.001$)	Significant ($p < 0.001$)
Relationship status	Significant ($p < 0.001$)	Significant ($p < 0.001$)	Significant ($p < 0.001$)	Not significant
Years of experience	Not significant	Not significant	Not significant	Not significant
Education level	Significant ($p = 0.014$)	Significant ($p = 0.037$)	Significant ($p = 0.009$)	Not significant

To ensure transparent reporting, we present both statistically significant and non-significant findings. This is particularly important in a context where some bullying behaviors may be low-frequency events and where the absence of differences across certain demographic categories is analytically meaningful for interpreting patterns of vulnerability and exposure.

There is a significant difference between the mean of total bullying and year of birth categories ($p = 0.021$), wherein participants born in 1990-2001 (mean = 33.478) were more bullied than those born in 1957-1967 (mean = 31.588), followed by those born in 1979-1989 (mean = 30.021). Also, between the mean of total bullying and relationship status, in that widowed participants (mean = 42.923) were more bullied than those who were in a relationship (mean = 29.985; $p < 0.001$) and between the mean of total bullying and education level, wherein those with a university degree (mean = 32.709) were bullied more than those with middle school level education (mean = 28.818; $p = 0.014$). There is a significant difference in the mean total bullying by profession type, with residents (mean = 44.212) being bullied more than nurses (mean = 31.048) and administrative employees (mean = 28.508; $p < 0.001$). There is no significant difference in the mean of total bullying by gender ($p = 0.537$) and years of experience ($p = 0.450$).

This pattern may reflect the structural position that residents occupy within healthcare hierarchies. Residency positions are typically characterized by high levels of professional dependency, intense supervision, and limited organizational power (Einarsen et al., 2020; Hutchinson et al., 2006). Residents rely heavily on senior physicians for training, evaluation, and career progression, which can create asymmetric power relations that make them particularly

vulnerable to negative acts such as excessive monitoring, workload pressure, and reputational harm. In crisis-affected healthcare systems such as Lebanon's, where organizational strain and resource scarcity intensify existing hierarchies, these vulnerabilities may be amplified. Under such conditions, bullying behaviors may become normalized as part of high-pressure professional socialization processes, disproportionately affecting individuals occupying transitional or trainee roles.

Widowed participants have higher means of personal bullying (mean = 22.692) than those who are single (mean = 17.3026) and those who are in a relationship (mean = 15.949; $p < 0.001$). There is a significant difference between the means of personal bullying and education level, wherein those with university degrees (mean = 17.308) are bullied more than those who have finished middle school (mean = 15.364) ($p = 0.037$). Residents (mean = 22.970) have higher levels of personal bullying than nurses (mean = 16.498) and administrative employees (mean = 15.358) ($p < 0.001$). There is no significant difference in the means of personal bullying by gender ($p = 0.468$), year of birth ($p = 0.179$), or years of experience ($p = 0.675$).

Those born in the years 1990-2001 have higher means of work-related bullying (mean = 11.780) versus those born in 1968-1978 (mean = 9.868) ($p = 0.002$). Widowed participants have higher means of work-related bullying (mean = 15.539) compared to married ones (mean = 10.667) and those in a relationship (mean = 10.201) ($p < 0.001$). Participants with university degrees have a higher mean of work-related bullying (mean = 11.325) compared to those with a middle school degree (mean = 9.705) ($p = 0.009$).

Residents (mean = 16.061) have the highest mean of work-related bullying scores compared to nurses (mean = 10.566) and administrative employees (mean = 9.791; $p < 0.001$). There is no significant difference between the means of work-related bullying and gender ($p = 0.364$) and between the means of work-related bullying and years of experience ($p = 0.181$).

There is a significant difference between the mean of physically intimidating bullying and years of birth categories wherein those born in 1990-2001 (mean = 4.1593) were bullied more than those born in 1979-1989 (mean = 3.7368) ($p = 0.041$). Also, residents (mean = 5.1818) were bullied more than nurses (mean = 3.9839) and administrative employees (mean = 3.3582) ($p < 0.001$). There is no significant difference in the means for physically intimidating bullying by gender ($p = 0.262$), relationship status ($p = 0.074$), education level ($p = 0.112$), or years of experience ($p = 0.777$).

The self-labelling method shows that 85.4% of participants reported not being bullied at work. Out of those who were bullied, 1.7% were bullied almost on a daily basis, 3.9% were bullied several times per week, and 8.5% were bullied only rarely. Following the section of being bullied at work in the questionnaire, the participants proceeded by answering who the perpetrator/bully was. The responses were as follows: bullying by colleagues (3.2%), by other managers/superiors at work (2.7%), by their direct manager/supervisor (1.5%), and by customers/patients/students, etc., together (1.0%). The other types of personnel bullies/perpetrators were minimal (< 1.0%) and thus not mentioned.

Furthermore, the participants stated that 5.6% of the bullies/perpetrators were both females and males, while only females were 3.6%, and only males were 2.9%. For female

bullies/perpetrators, those who were bullied once were 5.6%, twice 2.9% and three times 1.5%. For male bullies/perpetrators, those who were bullied once were 4.4%, twice 4.1% and three times 2.9%. The prevalence of bullying determined by the self-labelling method is 14.6%.

According to Notelaer's and Einarsen's estimation of the Received Operation Characteristics (ROC) curve analysis of cut-off values, participants who scored below 33 are not considered to be bullied (Notelaers & Einarsen, 2013); those who scored between 33 and 44 are considered moderately bullied, and those with scores equal to 45 and above are categorized as victims of bullying (Notelaers & Einarsen, 2013). This study showed that 71.5% of participants were not bullied at all (cut-off point < 33), 19.0% were exposed to moderate bullying (cut-off = 33-44), and 9.5% were victims of bullying (cut-off ≥ 45).

As for the cross tabulation and significant difference between the cut-off points of total bullying categories and the variables, 70.6% of those born between 1957-1967 have not been exposed to bullying, while 17.6% of the same group have been exposed to moderate bullying and 11.8% have been severely bullied ($p = 0.007$). For those born between 1968 and 1978, 80.7% were not exposed to bullying, while 12.0% were exposed to moderate bullying and 7.2% were severely bullied. For those born between 1979 and 1989, 73.7% were not exposed to bullying, while 17.9% were exposed to moderate bullying and 8.4% were severely bullied. For those born between 1990 and 2001, 57.1% were not exposed to bullying, while 29.1% were exposed to moderate bullying and 13.7% were severely bullied.

There is a significant difference between the cut-off points for total bullying categories and relationship status ($p < 0.001$); hence, 61.5% of single participants were exposed to bullying,

26.2% to moderate bullying, and 12.3% to bullying. For those who were in a relationship, 76.3% were not exposed to bullying, 16.5% were exposed to moderate bullying, and 7.2% were victims of bullying. For those who were married, 66.7% were not exposed to bullying, 16.7% were exposed to moderate bullying and 16.7% were victims of bullying. For those who were divorced, 66.7% were not exposed to bullying, while none was exposed to moderate bullying and 33.3% were victims of bullying. For widowed participants, 23.1% were not exposed to bullying, while 38.5% were exposed to moderate bullying and 38.5% were victims of bullying.

The results indicate that 81.8% of the participants with a middle school education level were not exposed to bullying, while 11.4% were exposed to moderate bullying and 6.8% to severe bullying. As for those with high school degrees, 76.9% were not exposed to bullying, 14.1% were exposed to moderate bullying, and 9.0% were victims of bullying; moreover, 62.6% of the participants with university degrees were not exposed to bullying, 25.3% were exposed to moderate bullying, and 12.1% experienced severe bullying ($p = 0.031$).

The results show that 77.6% of the administrative participants were not exposed to bullying, while 14.9% were exposed to moderate bullying and 7.5% were victims of bullying ($p < 0.001$). As for residents, 18.2% were not subjected to bullying, 42.4% were subjected to moderate bullying, while 39.4% were victims of bullying. As for nurses, 70.4% did not experience bullying, while 20.9% were moderately bullied and 8.7% were severely bullied. Moreover, there is no significant difference in the cut-off points for bullying categories by gender ($p = 0.515$) or by years of experience ($p = 0.383$).

The results suggest that bullying exposure in this crisis-affected healthcare context is expressed most strongly through routine and organizationally embedded forms of mistreatment rather than extreme physical intimidation. Although physically intimidating bullying showed limited subgroup variation, it remained rare overall and should be interpreted cautiously given the low internal consistency of this subscale. The dominant pattern concerns behaviors that shape everyday working conditions and interpersonal standing, such as work overload, close monitoring, exclusionary practices, and reputational harm, which become normalized under crisis conditions. These findings indicate that bullying operates as an organizationally patterned experience that is likely to be reproduced through unequal dependence, constrained voice, and heightened vulnerability within hierarchical healthcare workplaces operating under chronic strain.

Discussion

The findings advance workplace bullying scholarship by demonstrating that in crisis-affected healthcare organizations, bullying is most visibly reproduced through routine, organizationally embedded practices rather than extreme acts of physical intimidation. This supports a crisis-sensitive extension of workplace bullying frameworks in which institutional fragility amplifies structural and symbolic domination, and where vulnerability is shaped by status position and professional dependency (e.g., residents), as well as social stigma (e.g., widowhood, cf. Mousa et al., 2025), more than gender alone. The results, therefore, refine how bullying exposure and harms to well-being should be theorized in unstable organizational environments. Bullying operates as a chronic stressor that disrupts psychological safety and triggers stress-related

symptoms. In fragile-state settings, the cumulative exposure to bullying, economic precarity, and moral injury exacerbates emotional exhaustion and secondary trauma. Future interventions should therefore adopt a behavioral health approach, integrating counselling, peer support, and human resources (HR) mental health initiatives.

A key contribution of this study is to clarify the link between bullying exposure and employee well-being in a crisis-affected healthcare context. Consistent with a behavioral health perspective, the observed bullying behaviors represent chronic workplace stressors that accumulate over time and erode psychological safety, emotional resources, and professional functioning. In this setting, where staff already operate under heightened strain and uncertainty, even routine forms of bullying such as work overload, excessive monitoring, and reputational harm can intensify burnout risk and undermine well-being by normalizing insecurity, reducing perceived control, and weakening access to support.

Rather than indicating a pattern dominated by rare or extreme acts of physical intimidation, the findings suggest that workplace bullying in this crisis-affected healthcare context is primarily enacted through routine and organizationally embedded forms of mistreatment. The most prevalent behaviors cluster around symbolic and structural domination, including gossip and rumors, reputational harm, excessive workload, and forms of control that constrain autonomy and intensify pressure. These behaviors are particularly consequential because they operate through everyday organizational practices and interpersonal infrastructures that are difficult to contest, normalize over time, and erode psychological safety. In crisis settings where institutional safeguards are weakened and work intensification becomes

routine, such practices can become both more tolerated and more damaging, producing a cumulative pattern of harm that directly undermines employee well-being.

The findings also indicate that bullying exposure is not randomly distributed across the workforce, but clustered around status-based vulnerability and hierarchical dependency within healthcare organizations. Residents, younger employees, and widowed participants reported higher bullying exposure, suggesting that vulnerability is shaped by one's position in organizational hierarchies and one's access to credibility, voice, and protection, rather than by gender alone. Residents, in particular, occupy structurally dependent roles characterized by limited autonomy, intensive evaluation, and constrained capacity to refuse unreasonable demands, which heightens exposure to forms of bullying expressed through workload pressure, monitoring, and social exclusion. Similarly, widowhood may function as a socially salient marker of stigma and reduced protection in organizational environments, increasing susceptibility to reputational harm and interpersonal marginalization. In this sense, bullying in crisis-affected healthcare settings can be interpreted as an organizationally patterned outcome of unequal dependence and constrained voice, with direct implications for how psychosocial well-being risks are reproduced within fragile workplace systems. These patterns support a crisis-sensitive organizational account of bullying as cumulative domination embedded in everyday work relations, and they underscore the need for interventions that address organizational governance and protection rather than relying primarily on individual coping or training.

A study in Kuwait showed that workplace bullying was evident in employees who were younger, wherein exposure to workplace bullying dropped with increasing age (Alaslawi, 2017).

This was also observed in another study in Oman, where 14.5% of employees aged 33 years and younger were bullied at work, compared with those aged 34 years and older (Alhassan et al., 2023). While some research found no significant age effect on workplace bullying, others found that younger people were more likely than older people to experience workplace bullying (Al-Omari, 2015; Al Muharraq et al., 2022; Leymann, 1992; Ovayolu et al., 2014). Another explanation for our findings is that younger generations may not yet be able to defend themselves against bullying.

Viewed together, these patterns indicate that bullying exposure clusters around unequal organizational dependency and socially mediated protection, rather than being driven by gender differences alone. Widowed participants had the highest means of total bullying, personal bullying and work-related bullying. This may be due to the "humiliation" that widowed participants may have due to cultural reasons, wherein married participants may possibly feel more protected by their spouses. Widowed participants may find themselves powerless and vulnerable due to their condition (noting that they are widowed and may already have a difficult private life). Divorced and single participants had the highest rate of exposure to bullying in a study conducted in Kuwait (Alaslawi, 2017). This shows that divorced or widowed people in the Middle East, particularly women, may be subject to stigma. Hence, women are prone to experience bullying since carrying the family name of the spouse and a solid reputation may provide a sense of protection and belonging to them.

Participants with university degrees had the highest means for bullying, but not in physically intimidating bullying. Educated people may become more sophisticated and sensitive

to comments about their performance and may be less inclined to non-constructive criticism and feedback. For instance, nurses were 5.4 times more likely to experience verbal abuse if they had a bachelor's degree than if they had a high school diploma (95%CI [1.738-17.072]), and 7.2 times more likely if they had a master's degree (95%CI [1.905-27.815]) (Al-Omari, 2015).

Residents had the highest means of bullying. This may be because residents are relatively younger and spend less time than administrative and nursing staff and may not be inclined to receive derogatory comments. Residents may also express fear of not graduating in case they confront the supervisors who bully them, so they do not act against bullying. The vulnerability of residents can be further understood through organizational power and hierarchy dynamics. Residents occupy structurally dependent positions characterized by limited autonomy, high evaluation pressure, and constrained capacity to refuse demands, thereby heightening exposure to subtle forms of domination, such as punitive workload allocation, surveillance, and exclusionary practices. In crisis-affected healthcare environments, these hierarchical dependencies may become more pronounced as staffing shortages and institutional strain increase managerial discretion and reduce accountability for everyday mistreatment. Due to the nature of their profession, residents have an inherent kind of work and relationship with faculty members. Since their work is occasionally comparable to that of a medical attending, medical residents are not considered mere students or trainees. However, since they are still undergoing training in their specific fields, they are also not medical specialists or fully competent physicians until graduation (Álvarez Villalobos et al, 2023). Thus, they are in between being a physician and a trainer. On another note, bullying frequently follows a "pecking order" of seniority, and residency training follows a hierarchical field and this is why residents are often mistreated by

faculty with little ability to report or take revenge. Since residents are eager to learn, they tend to "absorb" all the bullying that takes place with them for the sake of learning and graduating.

Moreover, residents reported higher bullying exposure than other occupational groups. This pattern may reflect the structural position that residents occupy within healthcare hierarchies. Residency positions are typically characterized by high levels of professional dependency, intense supervision, and limited organizational power (Einarsen et al., 2020; Hutchinson et al., 2006). Residents rely heavily on senior physicians for training, evaluation, and career progression, which can create asymmetric power relations that make them particularly vulnerable to negative acts such as excessive monitoring, workload pressure, and reputational harm. In crisis-affected healthcare systems such as Lebanon's, where organizational strain and resource scarcity intensify existing hierarchies, these vulnerabilities may be amplified. Under such conditions, bullying behaviors may become normalized as part of high-pressure professional socialization processes, disproportionately affecting individuals occupying transitional or trainee roles. Bullying towards residents should therefore be interpreted not simply as interpersonal hostility, but as an organizationally patterned expression of unequal power and voice within professional hierarchies.

It is worth mentioning that many incidents still occur in the country today, and they are all unfortunate events amid worsening conditions. This indicates contextual changes, as the country faced many challenges that would increase stress levels. Another reason for underestimating the prevalence of workplace bullying is that some people may be reluctant to

acknowledge their victimhood and their bullying status and may fear that their bullies would find out about them.

On the other hand, HR should adopt a positive approach to career guidance, given the prevailing political, social, and economic challenges that may have an undesirable impact on the workplace. HR should become more adaptable by continuously evaluating and managing employees' career trajectories. They should attempt to prevent workplace bullying by initiating performance improvement interventions. Some examples of these interventions include creating policies to address workplace bullying, encouraging employees to report these acts without fear of prejudice or retaliation, adopting firm sanctions against those who bully, and raising awareness about workplace bullying during recruitment and selection of frequent awareness and training on the subject.

There is a scarcity of research on the interventions and measures of associations adopted to prevent workplace bullying, and which interventions are successful. For instance, a study in Saudi Arabia found that management encouragement was associated with a substantial decrease in exposure to workplace bullying (Alhassan et al., 2023). However, we believe that effective communication, with respect and constructive criticism, could help enhance employees' well-being. Making it clear that workplace bullying is not tolerated and taking immediate action to prevent such incidents indicates that organizations are taking this issue seriously.

HR should employ effective well-being interventions to support employees in these difficult contexts. In this case, HR is referred to as the "trusted listener", "objective, neutral third-party investigator", "management advisor" and "mediator/trainer/coach" (Djurkovic et al, 2021).

This entails employing experienced employees or training the HR personnel to be expert in this domain. By this way, they will carefully evaluate their employees' positions in these situations and prepare to address any potential unproductive activities. By this way, they can promote the well-being of their employees by continuously listening to their personnel and making sure that the communication between supervisors and employees is conducted in a smooth and fair way without any hurtful remarks. Even if workplace bullying rarely occurs in an organization, this should not mean that HR should not treat it as a priority, since its impact on employees' well-being can be enormous, even after duty hours. A valuable strategy for preventing workplace bullying is to improve the organizational culture, management techniques, and leadership.

Workplace bullying regularly takes the form of continuous negative behaviors such as intimidation, social isolation, and criticism. These actions can utterly harm employees' well-being and in turn negatively impact organizational effectiveness (Ståle Einarsen, Helge Høel, & Guy Notelaers, 2009). To successfully prevent and address workplace bullying, organizations should integrate awareness campaigns into recruitment and selection procedures and propose continuing training programs (Ståle Einarsen, Helge Høel, Dieter Zapf, & Cary Cooper, 2020). This comprises teaching and educating employees on what constitutes bullying and what is and is not appropriate (Djurkovic et al, 2021). Additionally, research has demonstrated that organizational support and psychosocial workplace circumstances are critical to employee performance, well-being, and the avoidance of burnout, underlining the significance of good HR practices in preserving a positive work environment (Evangelia Demerouti et al., 2019).

For HR practitioners, these findings underline the importance of proactive anti-bullying interventions within healthcare organizations, particularly in contexts characterized by institutional fragility and crisis (Tekeste and Özbilgin, 2026). Previous research shows that organizational climate, leadership behavior, and reporting mechanisms play a critical role in preventing bullying and protecting employee well-being (Einarsen et al., 2020; Hoel and Cooper, 2000; Salin, 2003). HR departments should therefore prioritize the development of clear anti-bullying policies, confidential reporting channels, identification and mapping of vulnerable groups (Özbilgin et al., 2025) and training programmes aimed at recognizing and addressing subtle forms of psychological harassment such as gossip, reputational damage, and excessive workload allocation. In healthcare organizations facing systemic strain, HR interventions that strengthen psychological safety and organizational justice can help mitigate the escalation of bullying behaviors and support employee well-being.

Implications for practice

The findings have implications for organizational governance in healthcare systems operating under conditions of crisis and instability. The dominant bullying behaviors observed in this study were not primarily physically intimidating acts but more routine and organizationally embedded forms of mistreatment, including work overload, excessive monitoring, and reputational harm. These patterns suggest that bullying prevention in crisis-affected healthcare organizations cannot be addressed solely through individual training or interpersonal conflict resolution, but requires interventions that reshape working conditions, accountability structures, and access to voice.

First, workload governance emerges as a core organizational priority. When work overload is a central bullying mechanism, anti-bullying policy must be linked to staffing, scheduling, and supervisory discretion, rather than framed only as a behavioral code. Practical measures include monitoring workload allocation fairness, reducing discretionary punitive task assignments, and embedding oversight into line-management practices. When policies are well-explained to members of an organization, they tend to have a far higher chance of being adopted and successfully influencing behavior especially targeting potential perpetrators. This type of clear policies with obvious and targeted interaction supports in the use of language that is simple and clear for the intended audience, which is more likely to have an impact on preventing bullying (Djurkovic et al, 2021).

Second, the findings highlight the need for strengthened procedural protection in reporting and response systems. In crisis contexts, staff may face heightened vulnerability and dependency, which can inhibit disclosure and amplify fear of retaliation. Organizations should therefore implement confidential and trusted reporting channels, ensure timely follow-up, and explicitly protect complainants from adverse consequences, particularly where hierarchies are strong and professional mobility is constrained.

Third, because bullying in this context appears to operate through everyday practices of surveillance, exclusion, and reputational damage, managerial accountability must extend beyond addressing severe incidents to recognizing cumulative patterns of harm. Supervisors and unit leaders should be evaluated not only on operational performance but also on the psychosocial

safety of work climates, with clear responsibility for preventing normalized forms of mistreatment.

Finally, individual-level supports remain essential, particularly given the well-being risks associated with sustained exposure to bullying behaviors. Access to psychosocial support, coaching, and counselling should be available, but such support should be positioned as complementary rather than substitutive: without organizational intervention, individual resilience measures risk shifting responsibility onto targets while leaving harmful structures intact. These implications underscore that bullying in crisis-affected healthcare settings is best addressed as an organizational and institutional challenge involving power, protection, and the governance of everyday working conditions, rather than as a standalone matter of interpersonal training.

Limitations

The study was held at a single medical center in Beirut; hence, it is difficult to extend these results to other programs across the country or other countries, even though there were some similarities. Workplace bullying is not examined over time due to the cross-sectional methodology. As a result, we were unable to verify the association between the variables, particularly given the study's descriptive design. There is reporter bias because participants might give answers that they think would be acceptable or because the survey is self-reported. Nurses were more responsive to the interviews, and reasons may be attributed to the fact that nurses may be more prone to filling out surveys, while residents who were relatively younger may not be that keen on filling out surveys. A further limitation is that the physically intimidating bullying

subscale exhibited lower internal consistency in this sample; we therefore interpret this dimension cautiously and focus the core discussion on the more robust bullying dimensions observed.

Conclusion

This study calls for a convergence between HR management and occupational behavioral health frameworks to protect employee well-being in volatile environments. It is fundamental to understand the effects of workplace bullying to prevent its incidence and to frequently monitor employees' well-being. Findings can direct future research to enhance the well-being of employees in healthcare organizations. The problem of workplace bullying in Lebanon has organizational, economic, and legal repercussions in addition to psychological and mental health ones. Once accurate information is collected from the Middle East region, researchers could combine assessment data from quantitative and qualitative methods and combine different individual diversities (such as personality, skills, and hobbies) into a unified whole. More thorough research is necessary from nations outside the Nordic region, like from the Middle East, relevant to the impact of workplace bullying on people, associations, and society, and the costs associated with it.

The findings highlight the need for organizational analysis of bullying that is sensitive to crisis conditions. Future research can build on this study by examining how institutional instability reshapes bullying mechanisms, particularly the expansion of everyday control practices such as workload pressure, surveillance, and social exclusion. In addition, the patterns observed here point to the importance of moving beyond gender-only framings and instead theorizing

vulnerability as status-based and context-dependent within organizational hierarchies. Finally, while survey evidence can clarify prevalence and group differences, further work using longitudinal and qualitative designs could strengthen understanding of how bullying is reproduced, normalized, or resisted within crisis-affected healthcare organizations and how these processes shape well-being trajectories over time.

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