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OCCUPATIONAL THERAPY PRACTICE FOR CHILDREN WITH ADHD IN EAST JERUSALEM: PROFESSIONAL VALUES, INSTITUTIONAL CONSTRAINTS, AND THE POLITICS OF CARE

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Abstract:
This study explores the description of practice by occupational therapists (OTs) in East Jerusalem working with children with attention deficit hyperactivity disorder (ADHD) and how their practice is influenced by professional values, expectations of change and institutional context. The rationale for this study is primarily based on observational evidence and gaps in the empirical literature in the field of occupational therapy for ADHD in politically contested, resource-limited, and culturally specific contexts, such as East Jerusalem, where Palestinian children experience the compounded burden of structural, geographic, and political barriers to care. **Methodology:** This study was conducted using a qualitative methodology, composed of semi-structured interviews of 29 occupational therapists working in school, clinic and early childhood services in East Jerusalem. Data were analysed using reflexive thematic analysis (Braun & Clarke, 2006). The results yielded six themes: session as negotiated space; aspirations and institutional reality; competing change agendas; professional values as practice driver; East Jerusalem as practice context; and navigating resistance and accommodation. The results disclose that the nature of the practice of OT in East Jerusalem is first and foremost a milieu of chronic under-resourcing, institutional discrepancy, political insecurity, and an almost-conspicuous absence of a collective professional infrastructure, instead of principally formal, theoretical or evidence-based protocols .Therapists routinely drew from sensory regulation (the intervention of choice), improvised given insufficient equipment and space, and balanced clashing mandates from parents, schools, and institutions. Cultural responsiveness, therapeutic relationship and individualization emerged as de facto core values underpinning structural constraint treatment practice. This study is the first empirical insight into occupational therapy in a community with ADHD in East Jerusalem and has important implications for education, service provision and policy change.

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Keywords: occupational therapy, ADHD, East Jerusalem, qualitative research, thematic analysis, professional practice, Palestine, structural barriers, sensory integration, cultural competency

1. Introduction

Background attention Deficit Hyperactivity Disorder (ADHD) is the most prevalent neurodevelopmental disorder among children and adolescents globally, with systematic reviews and meta-regression analyses approximating global prevalence at around 5–7% in school-going children (Polanczyk *et al.*, 2007; Thomas *et al.*, 2015), although a recent umbrella review (Ayano *et al.*, 2023) has reported a pooled prevalence of 8.0%, 10% in boys and 5% in girls. These epidemiological statistics are easily quoted, but attention needs to be paid to context: diagnosis is contextually contingent, with great variation in national contexts due to diagnostic culture, institutional capacity and the social meanings assigned to inattentive and hyperactive behavior (Conrad & Bergey, 2014). ADHD has been a major point of clinical and policy focus in Israel, but stark disparities exist between Jewish and Arab minorities in terms of ADHD identification, diagnosis and access to treatment (Ornoy *et al.*, 2016; Shehadeh-Sheeny & Baron-Epel, 2023).

The situation in East Jerusalem is especially entangled with its own issues. Palestinian East Jerusalem residents are permanent residents instead of citizens, which entitles them nominally to Israeli health services, but structural, geographic, linguistic and political barriers systematically deny access by all (Imam & Hamdan, 2021). Research has shown the almost total lack of systematic ADHD diagnosis in Palestinian schools, a serious deficit of Arabic-speaking clinicians and a political geography in which checkpoints, closures and institutional dislocation mean that for most families, regular therapeutic contact is impossible (Palestinian Vision Organization & Diakonia, 2017). These inherent deficits are coupled with their post-October 2023 deterioration of the East Jerusalem healthcare infrastructure (Qamhawi, 2024).

Even though this is the context of practice, OT is economically endorsed to treat ADHD, addressing function and participation through occupation-centered, sensory-cognitive and family-mediated practice internationally (Kelsch & Miller, 2016). In Israel, the formal practice of OT working with ADHD is embedded in a neurodevelopmental perspective related to executive function and sensory processing, with the intention of bettering daily occupational performance (Israeli Journal of Occupational Therapy, 2017). Yet little is known about how occupational therapists in East Jerusalem practice — what they do during sessions, the decisions they make and how professional values and structural constraints shape their everyday practice with Palestinian children with diagnosed ADHD.

This study fills this gap. The main research question is as follows: How do occupational therapists in East Jerusalem describe their daily practice with children with ADHD, and how is their practice influenced by professional values, expectations for change, and the institutional context? We conducted a qualitative study using semi-

structured interviews with 29 occupational therapists working in East Jerusalem. This study is a novel empirical contribution, including the first systematic account of OT practice for ADHD in this context and informs implications for professional education, service design and policy.

2. Literature Review

ADHD is now viewed as a neurodevelopmental disorder and is a valid heritable condition defined by persistent inattentive, hyperactive or impulsive behavior that is developmentally inopportune and causes global impairment in daily function across generations (Faraone *et al.*, 2021). The disorder is known as an occupational phenomenon rather than a neurological deficit from an occupational therapy perspective — a break in the engagement of the daily activities and roles necessary for development, participation, and wellbeing (Israeli Journal of Occupational Therapy, 2017). This conceptualization of ADHD, therefore, labeled it more as a disorder of doing vs. knowing, in which the most clinically salient issue would be the difference between what a child knew vs. what they were doing in context (Brown, 2006).

2.1 Theoretical Frameworks Embedded in Occupational Therapy Practice for ADHD

Occupational therapy conceptualization of ADHD is informed by five theoretical frameworks. The PEO model situates occupational performance as the transactional outcome of the transactional relationship of three interrelated domains; the relationship among the person, environment, and occupation, which continuously shape each other (Bass *et al.*, 2024b). The Person–Environment–Occupation–Performance (PEOP) model expanded this framework by adding a fourth construct—occupational performance and positioning the client narrative prior to goal-setting (Bass *et al.*, 2024a). The occupant-centered practice definition (Dancza & Rodger, 2018) contends that true occupant-centered reasoning must begin with a focus on the client and their context, determining a client-centered approach begins with the occupational role and performance difficulties before working down to person factors. The Social Model of Disability makes a distinction between impairment and disability — locating the latter within the environment and institutions which present barriers to equitable participation (Oliver, 1990). Last, the Neurodiversity Paradigm shifted the narrative of ADHD from an abnormality that needed to be cured to a natural type of neurodiversity that does not require normalization but only necessitates environmental accommodations (Ledesma, 2014; Zimmerman, 2013). All five frameworks share an explicit disavowal of within-child deficit framing and a common commitment to the recognition of prior experiences, environment, and structural conditions as having a primary role in accounting for occupational outcomes.

2.2 Identification of ADHD and Access to Services in East Jerusalem

A study of ADHD in Palestinian children in East Jerusalem describes structural exclusion at every stage of the care pathway. Palestinian children in East Jerusalem are also lacking systematically collected epidemiological data, and the Palestinian Vision Organization and Diakonia (2017) document the nearly complete lack of standardized identification methods in Palestinian Schools, a shortage of Arabic-speaking clinicians, and the absence of cross-culturally validated assessment tools. Israeli data, where they do exist, come from institutional frameworks that serve mainly in the 'Jewish' institutional context and do not disaggregate data in ways to render East Jerusalem Palestinians visible as a public (Barlev, Rivkin, & Milstein, 2020).

The discrepancy between Arab and Jewish ADHD diagnosis and treatment has been observed empirically. Using DSM-IV criteria and multi-informant assessment in a cohort of 7- to 9-year-old children, Ornoy, Ovadia, Rivkin, Milshtein, and Barlev (2016) reported ADHD prevalence rates of 9.5% among Jewish children and a significantly lower 7.35% among Arab children, with teachers' evaluations in the Jewish population 2.3 times higher than parental evaluations, compared to only 12% higher among Arab families — a pattern the authors attribute partly to differential clinical alertness and referral pathways rather than necessarily reflecting a true difference in underlying neurodevelopmental prevalence, consistent with known limitations of Western- and Hebrew-normed instruments applied to Arabic-speaking populations (Jaber *et al.*, 2020). A separate study using DSM-5-based parent and teacher rating scales similarly found comparable overall ADHD prevalence between Arab and Jewish children, but markedly lower rates of seeking diagnosis among Arab Muslim children (9.2%) compared to Jewish children (17.8%), with Arab Muslim children also receiving significantly less medication treatment — a gap reflecting differential access and care-seeking rather than differences in underlying prevalence (Shehadeh-Sheeny & Baron-Epel, 2023). Structural barriers previously documented (Imam & Hamdan, 2021) include the findings that only 40% of primary healthcare centers in East Jerusalem provide psychiatry and counseling services, while a geographical barrier created by the separation barrier, checkpoint unpredictability and Hebrew-only clinical encounters exacerbated access difficulties for the most disadvantaged families.

2.3 Occupational Therapy Interventions for Children with ADHD

Occupational therapy evidence base for attention-deficit/hyperactivity disorder (ADHD) spans various intervention modalities. A systematic review of intervention approaches was carried out by Kelsch and Miller (2016), who identified play-based, sensory-based, motor and cognitive approaches, and did not find evidence to recommend one over the other but proposed that individualized, profile-matched intervention planning is the most defensible clinical framework. Although sensory integration therapy is the most widely used OT modality by practitioners in clinical practice, it has a relatively weak evidence base and is most appropriately used in children whose sensory processing profile is central to their occupational impairments, based on Ayres (1972). Within the

OT-ADHD literature, the CO-OP approach, which is child-directed goal-setting that teaches metacognitive problem-solving, receives the most solid Level I evidence support (Kelsch & Miller, 2016). The most researched family-mediated OT intervention targeting attention and executive function (EF) for ADHD in the Israeli context is a parent-training model grounded in EF theory that demonstrates at multiple sites significant improvement in children's occupational performance, known as the Parental Occupation Executive Training (POET) program (Frisch *et al.*, 2020).

In contrast, few Palestinian schools operate within this Israeli educational framework; this renders the school PSY services and OT consultation infrastructure to which Israeli-curriculum schools have access structurally inaccessible to most Palestinian (ie non-Israeli-curriculum) schools in East Jerusalem (Qamhawi, 2024). Even before the spate of war, limited and inadequate specialist provision was further diminished in the post-October 2023 context (see most recently: Qamhawi, 2024), with shortfalls in health workforce funding documented and the Mental Health Response to trauma (Qamhawi, in preparation) replacing the routine neurodevelopmental provision required.

Material and Methods

3.1 Methodology and Research Design

We used a qualitative methodology in this study with a qualitative research design appropriate to exploring what occupational therapists' stories are and how they narrate and interpret their everyday practice. Qualitative research was particularly suitable as data that were focused on a study of lived experiences, professional meanings and the social processes through which practice is constituted — which is not easily quantified (Braun & Clarke, 2006). The study is framed from an interpretivist and constructivist paradigm emphasising subjective meaning, and where the realities of OT practice in East Jerusalem are multiple, context-dependent and shaped by the particular political, institutional and cultural conditions of this contested city.

The selected method was reflexive thematic analysis developed by Braun and Clarke (2006). The inductive and data-driven approach generates themes from the data rather than relying on prior established categories. This makes it well suited to research contexts where the goal is to represent complexities of practice and accounts of practitioners rather than to test a hypothesis that is already specified. This reflexive dimension of the approach implies recognizing the influence of the researcher's position on the interpretation, a particularly relevant consideration considering the inherent political sensitivity of the East Jerusalem context.

3.2 Population and Sample

The study participants included occupational therapists working with children with ADHD in East Jerusalem, who work in schools, clinics, and/or early childhood centers. East Jerusalem can be identified as a specific population context because the structural, cultural, and political conditions in this setting allow for a particularly difficult practice environment and might be considered as a population context that has not previously

been the focus of empirical OT research. Purposive sampling was used to ensure participants had enough professional experience and contextual knowledge to speak meaningfully to the research question (Etikan *et al.*, 2016). Selection criteria were being a practitioner in East Jerusalem, having direct experience working with children suffering from ADHD, and willingness to be interviewed in an audio-recorded semi-structured interview.

This leaves 29 occupational therapists included from the final sample. The years of practice ranged from 3 – 21 Years which gave the perspectives of early-career and highly experienced practitioners. Participants practiced in multiple institutional settings — school-based, clinic-based, and early childhood centers — which made it possible to examine how institutional context influences practice in a variety of delivery models. Ethical protocols were fully followed (informed consent, the right to withdraw, confidentiality of participants).

3.3 Data Collection

Primary data collection method comprised semi-structured interviews. This method allows for guided but unstructured discussions in which participants can elaborate on their experiences and the researcher can explore emergent themes (Kallio *et al.*, 2016). The interview protocol contained questions regarding practitioners' daily session descriptions, the tools and techniques they utilized, their professional values and aspirations, constraints they encountered, relationships with parents and institutional actors, and experience of practicing in East Jerusalem specifically. The interviews were conducted in Arabic, the participants' primary language of work, to minimize unduly influencing participants to conduct the interviews in a second language, which can affect the quality of responses and be counter to cultural safety in the interview encounter.

4. Results

Six themes emerged from the thematic analysis of interviews with 29 occupational therapists: Therapists' ways of describing, experiencing and understanding everyday practice with children with ADHD in East Jerusalem.

Theme 1: The Session as a Negotiated Space

Rather than structured protocols, therapists described immediate responsive adaptations that were guided by the child's arousal state, the environment, and the inevitable unpredictable interruptions from outside. Proprioceptive input, movement breaks, trampolines, heavy work, or animal walks were all strategies that every therapist said they started sessions with before working on cognitive or academic tasks. This pattern across school, clinic and early childhood settings is consistent with a prevailing professional belief that the nervous system of the child must first be organized before he can achieve intentional learning or skilled performance, as predicted by the foundations of sensory integration theory (Ayres, 1972).

Here is one of my therapist colleagues' non-negotiable foundational practice: "I am always starting with something sensory — some jumping, some pressure, the trampoline, some animal walks. Without that, the session doesn't move. The arousal level of that child dictates entirely whether I can do anything with that child when they come in. It feels like a lot of the session is just helping them to self-regulate (Therapist, school-based, 7yrs). The structural disruptor of sessions that stood out the most was environmental unpredictability. All participants of the study reported the non-nature of shared therapy rooms, noise from neighbouring classrooms, unanticipated interruptions and lack of dedicated therapeutic space as systemic characteristics of practice. Out of this bedlam came the therapists creating islands of predictability — sand timers, visual schedules, reward systems, putting down the plan for the session at the beginning for the child — in a remarkable instinct for the motivational architecture of ADHD and the obvious externally-mediated deficit in executive function.

Theme 2: A Gap between Professional Vision and Institutional Reality

The central and persistent tension across all interviews was the difference between what therapists perceived as best practice and what circumstances in their institutions allowed for. Instead, it indicated not episodic frustration but rather a structural practice feature — an ongoing constraint on every clinical decision.

Almost all informants identified the need for sensory gymnasiums, weighted materials, climbing structures, proprioceptive tools, and designated quiet rooms as milestones to achieving sensory integration techniques they deemed clinically essential. A therapist with 21 years of experience said: "*I want a mattress to push police officers into the bodies of children. They have to be able to pass somatic inputs to me*." These are tools (60 to 70 percent of the therapy) that simply are not done. Therapists exhibited incredible clinical creativity, such as repurposing household items, movement games, and online resources to mimic therapeutic feedback - repeatedly tempering their suggestions with reminders that these substitutions could not replace appropriate tools.

They also identified session frequency as insufficient clinically. This common approach of providing one session per week was repeatedly described as inadequate to achieve the repetition, consistency and cross-environment generalization required for an effective ADHD intervention. Administrative documentation demands were felt as displacing clinical thinking and relational work as competing demands. Exemplar accounts of direct institutional influence on clinical judgements where management circumvented therapeutic goals, granting higher priority to institutional compliance goals.

Theme 3: Change in Conflicted Expectations

Therapists spoke of wading through three competing and often contradictory demands: their own therapeutic aims; parents' wants and demands; and those dictated by their institutions. For example, parents constantly demanded immediate, tangible behavior change — that their child would be able to sit in their chair, pay attention in class, and

stop disrupting the class. Therapists indicated they actively educated parents to reconceptualize behavioral compliance as being a faulty measure of success, replacing it with measures of self-regulation, self-awareness, and strategic coping.

Behavior compliance was defined by worksheet completion, quiet sitting, and getting rid of disruption to other students by schools and institutions. This is the institutional vision, as it has been described by an older therapist: "We want the child to be a robot. Forever silenced, and forever still and forever compliant. This frame directly replicates the disabled institutional orders described by the Social Model of Disability (Oliver, 1990), in which ADHD is contracted as a failure of behavior and not a neurodevelopmental profile that requires environment adjustments.

In contrast, therapists described their personal therapeutic north stars as self-regulation, self-awareness and fuller integration with the life of the child: "*The thing that is most helpful to an ADHD child is understanding what she is dealing with and why her body is doing what it is doing and how to work with this. That change needs to happen. Because if he no longer pursued therapy, no one else would be able to help him. "You give him the tools*" (Therapist, school-based, 4 years).

To influence nursing practice and care delivery, a strong set of professional values must be implemented into nursing messages or an echo of perceptions.

Therapists did not report an explicit theoretical model (though some highlighted common loyalties to specific theories); however, transcripts revealed a common set of professional values that offered a de facto practice framework across interviews. The therapeutic relationship was reported by all but one therapist as being the primary common precondition of effective intervention. "*When I listen to the kid, it is key for me.*" (Therapist, school-based, 7 years' experience) "*I hear him soften and flow so beautifully throughout the session. Rather than a preference for radical individualization — the principled refusal to adopt a standardized approach — I take this to be a professional obligation: There is no answer that applies. What matters to this child could be nothing to another"* (Therapist, clinic-based, 5 years' experience)

Therapists similarly resisted seeing ADHD hyperactivity itself as troublesome, resisting a deficit and normalization narrative in both their practice and their messaging to teachers and parents. This was put most clearly by one therapist, who had 21 years of experience: "*I would never force her to stay in her seat or to remain still. Never. Hyperactivity is not the problem. The problem was, we only wanted them to be little robots, and if there is anything we have learnt in the last few years of parenting and life in general, it's that these little powerhouses can be anything but a robot. Unless you do that, unless you find the correct green light for the disorder, the correct outlet for the disorder, it is only a disorder"*. This build-up from the child's existing interests and skills to overarching goals of therapy was always framed as how to develop therapeutic engagement.

Theme 5: The Practice Context of East Jerusalem

All therapists spontaneously observed — in one way or another — that the concrete political, geographic, economic and cultural realities of East Jerusalem colored all areas

of their clinical practice. Not as a background contextual factor of your context, but as a direct clinical variable. Children often came to sessions emotionally high from prior encounters with soldiers, airstrikes, or even just waiting hours at checkpoints.

As one therapist put it, "*All around the Old City, kids live in fear of soldiers all the time. Miss, the policeman stopped us. Miss, we saw soldiers. They do not feel safe. The child who does not feel safe cannot self-regulate. The soldiers, their faces partially obscured, converged on the neighborhood one night last month. The child arrived in fight-or-flight by the next day. It was very unlikely any progress could be made before — we spent all month just stabilizing*" (Therapist, clinic-based, 5 years' experience). Checkpoint disruptions led to cancelled sessions in military closures and escalation sequences, resulting in direct violations of the therapeutic continuity supported by evidence-based ADHD intervention.

Scarcity was conceptualized as the assumed way of doing practice rather than as a special hardship: rooms that were too small, equipment that was frequently missing, split rooms, and the almost total absence of the infrastructural conditions (for example, professional infrastructure) to do ADHD work were the shared operating conditions of the 29 therapists. Importantly, all therapists reported the lack of a common clinical paradigm — with practice largely existing in professional isolation, without common language, shared standards or a collective professional community of practice.

Theme 6: Negotiating Resistance and Accommodation

Therapists described a range of strategies for coping with the associated structural constraints and competing demands. Several participants described advocacy, including educating colleagues, parents, and administrators; challenging common misconceptions about ADHD; arranging meetings across disciplines; and redesigning care plans in the context of institutional adversity, as a significant aspect of their professional role. Strategic compliance —altering the articulated aims or clinical lexicon to meet the institutional criteria while marshaling the deeper therapeutic intent in real sessions— was characterized by others as an expert style of survival, not professional surrender.

At the lower end of the stats, a small minority of therapists reported migrating toward profession departure, citing examples of colleagues who had left the field entirely after prolonged institutional resistance and no professional support. I have tons of therapies, professional troublemakers, who now are getting beaten up in their schools. No one stands behind them. No one supports them. And now, they were contemplating changing careers altogether. Then if only someone could come along and water your work, — believe in you — and all would be different. "*Well, you need that to leave it — the best of therapists do top off without it*" (Mend, 7 years' background, school-based, therapist).

5. Discussion

In summary, the six interdependent themes produced by this study coalesce here for one major finding: the practice of occupational therapy with children with ADHD in East Jerusalem is not dominated by formal evidence or theory, nor by structured professional

training, but rather by what can be described as a structural ecosystem of chronic lack of funding, institutional misalignment, political instability, and a near-absence of a shared professional infrastructure.

The result corresponded closely with the Norwegian data reported by Aas and Bonsaksen (2023), who found that only 38% of OT interventions delivered in the hospital and rehabilitation contexts received occupation-based classification, even though therapists highly endorse occupation-centered professional values —a disparity largely attributed to external workplace pressures, documentation requirements and the implicit dominance of the biomedical model. In East Jerusalem, this disparity between our ethos and what we actually do is even more pronounced, as the structural prerequisites for an occupation-relevant orientation — a dedicated therapeutic space, frequent sessions, inter-disciplinary exchanges, a school consultation framework, and common professional standards — are largely absent or constrained.

The widespread acceptance of sensory regulation as a beginning point across contexts represents not just independent clinical judgment on a large scale, but a hallmark of professional consensus that developed – before the introduction of formal recommendations. This adds weight to the assertion in the international literature that the rationale of sensory integration reasoning has become a prevailing normative discourse in OT for ADHD despite the current evidence for its universal application being limited (Kelsch & Miller, 2016). Practically, this means that professional education and service development for OTs in East Jerusalem should focus some of its attention on debating the specific contexts in which sensory-based approaches vary in their appropriateness — a distinction that practitioners' own accounts suggest, in situations of resource scarcity, is too often elided in day-to-day practice.

Across all 29 participants, a common structural professional gap was identified as the lack of a shared clinical paradigm, with direct ethical and practical implications. In the absence of common standards, care quality is entirely dependent on the individual therapist they encounter — a result that is both professionally troubling and ethically indefensible for children who are already experiencing cumulative structural dis-exclusion. An ethnographic study of ADHD diagnosis in Portugal by Filipe (2016) provides a theoretically generative parallel: she shows that diagnosis is always a situated process of selective mobilization of global standards and local clinical realities that generates markedly different results. The same reasoning is true for intervention: Occupational therapy for ADHD in East Jerusalem does not represent a locally specific variant of a globally standardised protocol, but a practice that is situated within the particular political, institutional and cultural conditions of this contested city.

The political dimension of practice — in articulated form most prominently in Theme 5 — is the most original contribution of this study to the international OT literature. Children coming to therapy sessions in hyperaroused states related to checkpoint encounters in the context of military incursions or other forms of political violence do not come with ADHD related dysregulation alone; they are arriving with the functional effects of chronic political trauma that is not only phenomenologically

indistinguishable from, but that also functionally exacerbates ADHD presentation (War Child, 2025). The significance of this finding extends to assessment: common ADHD rating scales standardized in Western, politically stable contexts are not able to differentially characterize neurodevelopmental ADHD vs. adversity-related attentional dysregulation in this population (Aloshi & Majadley, 2024). In terms of intervention: environmental hyperarousal generated by political insecurity cannot be treated as if it were a clinical issue, and clinicians' anecdotal reports of using their entire hour session merely to stabilize children after political events confirm this clinical reality.

The description of the conflicting expectations of change in Theme 3 highlights the nonalignment of the philosophy of occupation-centered professional practice and the behavior compliance goals of the institutional setting. This finding resonates with theoretical critiques of both the Social Model of Disability (Oliver, 1990) and the Neurodiversity Paradigm (Ledesma, 2014; Zimmerman, 2013), both of which characterize institutional demands for behavioral normativity as disabling circumstances that — rather than merely react to — produce functional impairment. Even when consistent with structural exigency, the active resistance of therapists to normalization agendas, and their proactive cultivation of strengths-based, client-centered, relationship-centered practice as de facto organizational architecture, suggests a type of professional agency that is both ethically consistent and functionally flexible.

6. Conclusion

It presents the first empirical account of occupational therapy practice in East Jerusalem for children with ADHD, producing six themes that, in combination, appeared to construct a practice more rooted in the structural ecology than clinical formalities. Sensory regulation, therapeutic relationship, radical individualization, and strengths-based engagement were consistently prioritized by therapists — values that formed an informal clinical framework that arose to fill a void in practice standards, resources, and institutional support.

TD does stay up to date with the key findings, which highlighted that occupational therapists working in East Jerusalem practice within a context of structural exclusion so severe that it cannot be overcome by exercise of clinical skill at the individual level. For the sake of this argument, system-wide absence of intentional therapeutic space, suitable sensory equipment, frequency of sessions, school consultation capacity to cater to parents from Arabic-speaking backgrounds…and a community of practice are systemic deficits that individual professional agency — however innovative and dedicated — cannot substitute for. The interlocking political realities of East Jerusalem — checkpoints, incursions, eviction and settler violence, and persistent trauma — are not peripheral context, but rather core clinical variables in every session.

There are some major limitations mentioned in the study. An additional factor was that our sample was limited to the 29 therapists available within the constraints of our study context; such that the political volatility of East Jerusalem in particular after

October 2023 has both influenced participant availability as well as the content of interviews. A reflexive thematic analysis is used—the method is relevant to the research question, but reflects interpretation by the researcher rather than one objective account of practice.

5.1 Implications for Practice

Future research should investigate the views of families as well as children about OT practice with ADHD in East Jerusalem, and the ways in which professional development and communities of practice may assist therapists. The influence of digital transformation on service delivery (for example, how remote and hybrid OT models could broaden access in settings with structural barriers to physical access) is an especially timely avenue for future research.

This study confirms that access to effective and equitable OT for Palestinian children with ADHD in East Jerusalem in the long-term hinges not only on individual practitioner skill and resilience but also on structural investment in professional infrastructure, culturally validated tools and Arabic language resources, and indeed the political conditions which make therapeutic continuity possible.

Conflict of Interest Statement

The author declares no conflicts of interest.

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