

Central yet marginalized: a study of how other professional actors position teachers in working with student health

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Abstract

Purpose – The aim of this study was to investigate how teachers are positioned within the narratives of other professional actors with regard to working with student health. This report addresses two main research questions: “How are teachers positioned by other professional actors in the context of working with student health?” and “What roles are teachers assigned in student health work within the narratives of these professionals?”

Design/methodology/approach – A qualitative design with an interactionist approach was adopted to examine the position and roles assigned to teachers when working with student health. Interviews were conducted with nine principals and members of the student health team at two large Swedish high schools. Responses were transcribed verbatim and analysed using thematic analysis and the theoretical framework.

Findings – Teachers are given both a central and a marginalized role. Although they are sometimes described as essential for student health, they are rarely positioned as competent within this work.

Practical implications – The emphasis on high-quality teaching as a contributor to student health represents a practical pathway for schools. Teachers should be supported in creating inclusive, participatory and structured classrooms that inherently promote well-being.

Originality/value – This paper is the first of its kind to examine roles and positions assigned to high school teachers when working with student health in a Swedish context. The results are also valuable in other contexts. Since promotion of student health requires teamwork, it is essential for the main actors to understand each other’s roles and potential contributions, which this study contributes to.

Keywords Pedagogy, Educational practice, Social interaction

Paper type Research paper

Introduction

In recent years, growing expectations have been placed on teachers to engage with student health, both on a global scale (Gunawardena *et al.*, 2024; Berg *et al.*, 2024; Tamburrino *et al.*, 2020) and specifically in Sweden (SFS, 2010; Education, 2023), where the present study was conducted. This expanding professional role raises critical questions regarding the boundaries of teachers’ responsibilities, and the extent to which they should be involved in student health initiatives. Student health issues are often perceived as falling outside the traditional scope of teachers’ professional domain (O’Reilly *et al.*, 2018), and many educators feel inadequately prepared to address them (Tamburrino *et al.*, 2020; Askell-Williams and Cefai, 2014; Mazzer and Rickwood, 2015). At the same time, due to their close connections with students, teachers may feel morally or relationally compelled to become involved with health-related situations, which can create tension between their instructional duties and the emotional labour required to support student health (Willis *et al.*, 2019). Conversely, some studies suggest that teachers consider addressing student health to be an integral part of their professional identity and daily

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teaching practice, and feel confident and capable in this role (Hammerin and Basic, 2024; Maelan *et al.*, 2018).

In many schools in Sweden, student health team (SHTs) play a central role in addressing student health concerns, bringing together healthcare professionals with expertise in various fields. It has been reported that teachers sometimes engage with student health issues that SHT members consider beyond the teachers' professional expertise (Hylander and Guvå, 2017). This lack of clarity regarding professional roles and boundaries contributes to teacher stress and burnout (Ekornes, 2017; Mazzer and Rickwood, 2015) and also hampers effective collaboration between teachers and the SHT, leading to miscommunication, confusion, and inadequate support for student health.

School leadership is a pivotal factor affecting the effective fostering of health promotion in schools. Leaders influence the coordination of SHT efforts, and teachers' approaches to student health (Bush, 2022; Kostenius and Lundqvist, 2022; Skott, 2022). Research findings emphasize the importance of school leaders prioritizing health promotion, valuing it as a core educational responsibility, and facilitating cross-professional collaboration (Skott, 2022; Kostenius and Lundqvist, 2022). Moreover, school leaders' attitudes towards and knowledge about health promotion has significant impact on the school practice (Adams *et al.*, 2023). Thus, school leaders have key roles in defining and supporting the intersection of teaching and student health.

The aim of this study was to investigate how teachers are positioned within the narratives of other professional actors, with regards to working with student health. This was achieved by exploring the perspectives from two critical groups: members of the SHT and school principals. Specifically, the following research questions are addressed: "How are teachers positioned by other professional actors in the context of working with student health?" and "What roles are teachers assigned in student health work within the narratives of these professionals?"

Previous studies show that the roles of the teacher in student health work are complex and varied. Douwes *et al.* (2024) identified four roles that teachers perceive themselves as having in their work with students' mental health: Awareness Raiser, Connector, Referrer, and Guardian.

The Awareness Raiser role involves recognizing early signs of mental health issues and engaging in conversations with students about mental health, both individually and in general. In the role of Connector, teachers emphasize the importance of being available and trustworthy so that students feel comfortable confiding in them. The Referrer perceives their role as merely acknowledging or identifying mental health concerns and subsequently directing students to other professionals. The final role, the Guardian, is characterized by boundless availability, time, and attention dedicated to students' mental health. This role strongly emphasizes accessibility beyond regular working hours and meeting students' expectations and needs (Douwes *et al.*, 2024).

White and LaBelle (2019) examine university teachers' perspectives on working with students' mental health, with a focus on communicative roles and strategies. Four roles emerge: Empathic Listener, Referrer, First Responder, and Bystander. The role of the Empathic Listener is described as demonstrating compassion when students are struggling and actively listening to their experiences. The referrer is a role in which maintaining professional boundaries is of utmost importance. Rather than engaging personally, these teachers focus on promptly directing students to university mental health services if they wish to discuss health concerns (White and LaBelle, 2019).

The role of the First Responder differs from the first two in that teachers describe being attentive to signs of mental health issues. For instance, they look for behavioural changes and may ask students to meet them after a lecture to discuss observed signals. They then refer students to student health services or reach out to them directly. The final role, that of a bystander, entails that the teacher has no involvement or responsibility regarding students' mental health (White and LaBelle, 2019).

This paper explores the roles of the teacher from another perspective, focusing on the roles and positions assigned to the teacher by other professionals in the school context.

The concept of health

Health is a complex concept with several definitions and perspectives. The different meanings ascribed to the concept can be viewed as a reflection of the current time and society (Charmaz *et al.*, 2019). Even so, the meaning of the concept is sometimes taken for granted and the medical science often dictate what is health and ill-health (Quennerstedt, 2007). The understanding of the concept can be roughly divided into two main perspectives; the pathogenic and the salutogenic perspective.

The perspective commonly referred to as the biomedical or pathogenic perspective (Quennerstedt, 2007) focuses on the body, causes for disease and illness and how that can be cured or prevented. Health is viewed in a normative way where being healthy is the norm and being ill or unhealthy is a deviation. Health is defined as a state free from disease, illness or injury and it is a dominant perspective in several areas including medical science and partially in health care (Quennerstedt, 2007).

The other perspective, the holistic or salutogenic perspective, has its origin in work by Antonovsky (1987) and focuses on the whole person, health and health promotion. Health is not viewed as something you either have or do not have, instead there are varying degrees of health which are created and maintained in a process. Health is defined as a continuum where health and illness is not a dichotomy, hence an individual can have an illness yet experience health. Conversely, an individual can be free of illness and injuries but still experience ill-health (Eriksson, 1996).

The Swedish context

Internationally, as well as in Sweden, there is an ambition to apply multi-professional collaboration to successfully address both students' school problems and student health. During the last decade, attitudes towards student health have changed, at least on the legislative and policy levels. Specifically, there has been a shift from a more pathogenic perspective, with problems believed to stem from individual shortcomings, towards a salutogenic, preventive, and holistic approach (Guvå and Hylander, 2012; Hjörne and Säljö, 2021).

Today, schools in Sweden are required to include an SHT comprising professionals with knowledge in medicine, psychosocial problems, and special education. This team is intended to collaborate and bring their different professional perspectives to interprofessional discussions about students' health and school problems. However, research findings have revealed challenges to this interprofessional cooperation (Hjörne and Säljö, 2014; Kostenius and Lundqvist, 2021; The National School Inspectorate, 2021; Reuterswärd and Hylander, 2017).

An amendment to the Swedish Education Act, from July 2023, stipulates that the SHT should cooperate with teachers, who have been identified as crucial in promoting student health and well-being (De Wit *et al.*, 2011; Warne *et al.*, 2017; Pössel *et al.*, 2013). *Guidance for Student Health Services*, an electronic resource written by The Swedish National Board of Health and Welfare and The Swedish National Agency of Education (2023), states: "Student health work is carried out in all school environments, not to mention the classroom where the teacher plays a central role". Furthermore, teachers' responsibilities for working with student health are explained as including participation, fostering trusting relationships with students, and adjusting their teaching to fit the class (SFS, 2010; Education Act, 2023). One example of how to do this is through *additional adjustments*, which are regulated in the Education Act. This guidance states that if a student is at risk of not meeting the educational goals, the student should receive timely support in the form of additional adjustments within the regular teaching (SFS, 2010; Education Act, 2023).

In Sweden, there are significant differences between schools regarding student health work. In some schools, SHTs are incomplete, and their work is carried out without collaboration with teachers. In other schools, well-developed and effective cooperation exists between SHTs and teachers (Löfberg, 2018). The Swedish National Agency for Special Needs Education and Schools offer an online course for principals and SHT members aimed at strengthening schools' student health competency. A study by Hylander and Skott (2020), is a follow-up study of this course. The authors identify central aspects in developing student health competency. The principal's leadership and working together with other key actors, a comprehensive perspective of the educational mission and interprofessional cooperation, are such aspects.

Despite these modifications in terminology and perspective on a policy level, there appear to have been limited changes in the actual work. Members of the SHT express that they carry on as usual, and that not much new is done with regards to working with the students (Guvå and Hylander, 2012). Recent studies show that SHT and teachers still work on health and learning separately to a large extent, and that there is a lack of cooperation and consensus regarding what school health work actually entails for the different professionals (Kostenius and Lundqvist, 2022). The intentions on the legislative and policy levels have proven difficult to establish in school practice partly because these changes challenge the concept of schools as a place where teachers work with students, encouraging the perspective of schools as places for collaboration between different professionals working together to foster pupil health and learning (Hylander, 2016; Törnsén, 2018).

Method

The empirical data used in this article were collected in association with a larger qualitative study conducted in two Swedish high schools (School A and School B). Both are large schools, with approximately 1,500 students, and run by the local municipality. These schools were selected through convenience sampling, and based on their large size and the possibility to collect rich data.

This study received ethical approval from the Swedish Ethical Review Authority (nr. 2021–05748–01). For recruitment, the researcher contacted professionals from both schools either in person or via e-mail. The inclusion criterion was a minimum of two years working experience in their respective professions. A total of nine professionals participated in the study—including three principals, two student nurses, two student counsellors, and two special educational needs coordinators (SENCOs). These professionals had different educational and professional backgrounds. The interviewed SENCOs were experienced teachers with additional training in special educational needs. The principals were teachers with additional training in school management. The school nurses had healthcare education, with additional training regarding child health and well-being. The school counsellors had education in social work. The participants each had between 3 and 19 years of working experience in their respective professions (see Table 1).

Data were collected using exploratory individual interviews, with an interview guide (Cohen *et al.*, 2018). These interviews were recorded and transcribed verbatim. The analysis

Table 1. Participants

School A	School B
2 principals 1 school counsellor	1 principal 1 school counsellor 2 student nurses 2 SENCOs

has its starting point in thematic analysis, following the method described by [Braun and Clarke \(2006\)](#). The process began with reading and re-reading the material, followed by Features in the material related to the aim and research question were extracted and coded. This was a data-driven process where the school context was taken into consideration. The codes were sorted into themes based on patterns, similarities and differences.

Being mindful of assumptions, the use of theory and constantly comparing the codes and themes with the empirical material as a whole contributed to reliability and helped minimize researcher bias.

Theoretical framework

The theoretical underpinnings of this study are interactionist, regarding the individual's interaction via language, actions, and gestures ([Mead, 1972](#); [Blumer, 1969](#)). It is through social interaction and our own interpretations that we assign meaning to symbols and develop roles and identities ([Blumer, 1969](#)). Interactions are viewed as both experience-establishing and important for the creation and re-creation of positions and roles. Classic interactionism is focused on how an individual defines a situation, how an individual presents themselves in various situations, and how an individual's roles are created, maintained, and re-created ([Blumer, 1969](#)).

Role theory

In this study, the term "role" is viewed as dynamic, as opposed to static. Roles are continuously created and redefined through interaction ([Mead, 1972](#)) and an individual can have several different roles at the same time—for example, a professional role, gender role, and role as a parent or sibling ([Basic et al., 2021](#); [Greve et al., 2021](#)).

An individual holds multiple roles that vary depending on context and time. Roles may disappear and new ones may emerge throughout life, and sometimes multiple roles can merge into a composite role ([Eriksson and Markström, 2000](#)). The role an individual holds influences their capacity for action ([van Langenhove, 2021](#)).

In groups, different roles emerge among individuals to facilitate the group's functioning. These roles may be explicit or implicit and can be described as a combination of an individual's expectations of themselves, the expectations of other group members, and expectations from individuals outside the group. Roles may be assigned based on rational criteria, such as formal competence, but also on implicit grounds to meet the needs of the group ([Eriksson and Markström, 2000](#)).

Roles are dynamic, as they are linked to a broader societal context beyond the group itself. Societal changes, such as shifts in norms, values, or policies, contribute to the evolution of roles. Furthermore, an individual's own interpretation of their role influences and can actively reshape it, just as the role itself can influence and reshape the individual ([Eriksson and Markström, 2000](#)).

Positioning theory

Within the above-described theory, an essential analytic starting point is that when describing interactions, actors will position themselves and others as part of the creation of roles. In accordance with [Moghaddam and Harré \(2010\)](#), this study takes the standpoint that people use words and discourse to position themselves and others. Positioning is the mechanism through which roles are assigned, appropriated, or denied ([van Langenhove, 2021](#)). A position is defined as a collection of specific beliefs in the context of rights, duties, and obligations, which is central to how people build themselves and others through discursive activities ([van Langenhove, 2021](#); [Anderson, 2009](#)). A person's position affects their possibilities and opportunities to act ([van Langenhove, 2021](#)). Thus, the sixth step of the analysis focused on parts of the empirical data where the professionals described beliefs, duties, obligations and actions connected to student health work and teachers.

Self-positioning refers to people positioning themselves, and *other positioning* to people positioning others. These actions are codependent; to position oneself, you need to position others, and vice versa (Harré and Langenhove, 1991).

This study particularly examined other positioning in depth—including both *direct* and *indirect* other positioning. Direct other positioning refers to an actor directly positioning others by talking directly about them (and thus indirectly positioning themselves). Indirect other positioning is when an actor positions others by talking about themselves (self-positioning) or about other actors.

Positioning is dependent on context. In this study, the overall context is Swedish upper secondary school, and the specific context is student health work and the two schools. The term *professional domain* is used to denote a domain established by professionals in social interaction, through the definition of specialized knowledge, norms, and practices to differentiate them from other professionals (Freidson, 2001). This term allows the analysis of how professionals define boundaries around their work, protect their expertise, and develop status or authority.

Analysis

Analysing the study material revealed various positions for the teacher in working with student health. Both the SHT professionals and principals primarily started by discussing the SHT, and thereby indirectly positioned the teachers. Teachers were directly positioned only in rare instances. Comments about teachers' competency regarding student health work were ambiguous. Student health was primarily portrayed as within the professional domain of the SHT, in terms of expertise and competence. Overall, teachers were positioned in two somewhat contradictory positions: on one hand, indirectly subordinate, marginalized, and less competent; and on the other, central and indirectly ambiguously competent.

Indirectly subordinate and marginalized

In one interview, a principal was asked about the role of teachers in working with student health. In response, the principal did not describe this role, but instead discussed the SHT. He expressed a desire for the SHT to be located physically closer to the teachers' offices, to facilitate informal meetings. He felt that this would be beneficial for the students. When asked how this would benefit the students, he answered as follows:

Well, then the teachers could get more answers to their questions or be challenged in their way of thinking . . . a bit quicker. It would benefit the students' wellbeing. (Principal, School B)

In this excerpt, the principal indirectly positions the teachers by first talking about the SHT, i.e. indirect other positioning. When the principal expresses that closer physical proximity to the SHT would help the teachers "get more answers to their questions", he is positioning the teachers as subordinate, less competent, and in need of answers from the SHT. The principal also positions the teachers as having responsibility for student well-being. The SHT are positioned as superordinate and possessing answers that the teachers need, indicating that they are more competent than the teachers in working with student health. The principal further states that the teachers would be "challenged in their way of thinking", indicating that the teachers must think differently, in a way that will be more beneficial to "the students' well-being", and that the SHT can help them achieve this way of thinking. The teachers are positioned in a role as subordinate and requiring support, while the SHT are constructed as superordinate and as holding answers and the "right way" of thinking.

Teachers were also positioned as subordinate and less competent by indirect positioning through self-positioning. In the example below, a school nurse has been discussing her own student health work, and was asked about what the teachers do in this area.

It has been different things. In biology, for example, I have helped a teacher. We have divided the biology lessons regarding sexuality, consent, and relationships. Sometimes I have been out there

myself, and done one part, the biology teacher another. Sometimes I have done everything. (School nurse 1, School B.)

When the school nurse tells about how she has “helped” a teacher, she positions herself as superordinate and having a competence-based advantage. Simultaneously, she indirectly positions the teacher as subordinate in terms of competence in student health. She further mentions that they “divided the biology lessons”, meaning that the school nurse has entered the teacher’s professional domain: the classroom and teaching. Dividing the lessons somewhat implies positioning of the teacher as an equal, with the teacher covering some areas and the school nurse other areas. However, the school nurse continues by saying that she has sometimes “done everything”. In this statement, the school nurse is constructed as knowledgeable, competent, and superordinate relative to the teacher, and she presents herself as both a healthcare provider and an educator. In contrast, teachers are constructed as needing help, less competent, and marginalized even within their own professional domain.

The excerpt below provides another example of teachers being positioned as marginalized and less competent. A school nurse talked about making additional adjustments, which is considered a part of the teacher’s professional domain. When asked about how this relates to student health, the nurse explained as follows:

Well I have had some instances where I go in and write down additional adjustments for the students. And why would a school nurse do that? Well, because I can, so why not do it? (School nurse 2, School B)

The school nurse explained that she has sometimes written additional adjustments in student files. She acknowledges the unconventionality of this act by asking the rhetorical question “And why would a school nurse do that?”, and follows this with the justification “Well, because I can, so why not do it?” This statement reflects a self-assigned autonomy, with the school nurse challenging the rigidity of professional domains by asserting a capability and willingness to act. With this statement, she positions herself as someone who can justifiably perform a task that would be considered within the professional domain of the teacher.

By assuming a task traditionally associated with teachers, the nurse indirectly positions teachers as either unable or unavailable to perform this task in specific situations. While the nurse is not overtly critical, the act of assuming responsibility for additional adjustments suggests that she perceives a gap or unmet need in the teachers’ capacity to address this aspect of student support. This positioning subtly challenges the exclusivity of the teacher’s domain, and suggests that other professionals—including school nurses—can and should step in when necessary.

The act of a school nurse writing additional adjustments demonstrates the fluidity of roles within the professional domain of student health and education. Traditionally, writing additional adjustments for students is part of the teacher’s role, as it directly relates to classroom management and the individualization of education plans. By taking action in this domain, the nurse redefines her own role to include academic accommodations tied to health needs. She challenges the boundaries between roles, emphasizing the interdependence of teaching and student health work. This can be viewed as highlighting the shared goal of fostering student well-being, which justifies role flexibility in practice.

The nurse’s actions blur the lines between healthcare and academic support roles, reflecting the interactionist idea of role fluidity and negotiation. She challenges conventional role boundaries in the professional domain, by justifying her input in writing additional adjustments, which is typically reserved for educators. This aligns with the interactionist view of roles as dynamic and negotiated rather than fixed, particularly in this setting where the primary goal of improving student well-being is shared across professional domains.

Central and indirectly ambiguously competent

Direct positioning of teachers was less common in the study material. When the professionals directly positioned teachers, it was common to position them as having a gate-keeping role

because of their daily interactions with the students. A school counsellor explained that her job is to help students but that she does not always know when a student needs her help, as follows:

That teachers signal when students are in need of help. It is not always the student who signals. But that the teacher sort of . . . I am dependent on the teacher signalling to me. (School counsellor, School A)

In this statement, the speaker directly positions teachers as critical intermediaries who can identify student needs. The counsellor positions the act of “signalling” as a core responsibility of teachers, emphasizing their role as the primary observers of student behaviour and well-being. This positions teachers as frontline actors in the student health framework, who serve as a bridge between students and other professionals, such as counsellors, school nurses, and special education staff.

By highlighting her own dependency on teachers to “signal”, the speaker implicitly assigns teachers a gate-keeping role, in that the initiation of further support relies on the teachers’ ability to observe and report student needs. This framing reinforces a hierarchical positioning, in which the teacher’s observations and actions are foundational for enabling the work of other professionals.

The counsellor self-positions as being reliant on teachers for crucial information about students’ needs. This dependency reflects an interactionist view of professional roles as interdependent, with collaboration and communication being necessary to fulfil the shared goal of supporting students. The phrase, “*I am dependent on the teacher signalling to me*” constructs a narrative of reliance, framing the counsellor’s role as reactive rather than proactive, as she cannot intervene without teacher input.

This self-positioning also reflects a division of labour within the professional domain—with teachers positioned as the initial identifiers of issues, while the counsellor’s role begins only once a signal is received. This delineation underscores the interactionist perspective that roles are contextual and collaborative, evolving through mutual engagement among professionals. However, the counsellor does not mention any possibility of the teacher actually working with student health, merely noticing and signalling the need for other professionals to step in.

In the narratives, it was also uncommon for teachers to be positioned as central and competent regarding student health work. However, there were some empirical sequences in which the teacher was directly positioned, and student health work was described as within the teachers’ professional domain. The following example is from an interview with a SENCO:

Interviewer: Would you say that the teacher is important in working with student health?

SENCO: Yes.

Interviewer: Why?

SENCO: Well . . . I see the teachers as the nave in student health work really. Because it is them who are going to assess the students. Here in high school they set the grades and . . . I mean, it becomes very clear and evident if it works or not. And it is them who the students meet first. We (The SENCO) cannot create these contexts, so the teachers are responsible for their classroom and their teaching.

The SENCO explains that she views teachers as the “nave” in student health work, assigning them a central position. Here the SENCO uses direct other positioning, highlighting teachers’ pivotal role in assessing, guiding, and directly influencing student experiences within the classroom. This is a high-stakes positioning, as it assigns teachers not only an educational role but also significant responsibility for indirectly monitoring student health through their daily interactions, decisions, and classroom management.

Furthermore, teachers are positioned as the primary contact points for students, indicating that their roles extend beyond instruction to encompass initial emotional and social support. In stating that teachers are the ones who “meet the students first”, the SENCO suggests that teachers are in a position of influence in terms of both academic and personal dimensions of

students' lives. This positioning also reflects a dynamic and evolving role negotiation, in which teachers are positioned as pivotal actors in ensuring students' academic success and overall well-being.

Clearly, the professional domain of student health work extends beyond the traditional boundaries of healthcare or special education, suggesting that all educators have roles in fostering student well-being. This reflects that the professional boundaries are not fixed, but are instead co-created through interactions in the school environment.

The SENCO further states that "it becomes very clear and evident if it works or not", indicating her view that teachers are not always competent in student health work. This also implies that she can determine whether it works or not. She says that "we [meaning the SENCOS] cannot create these contexts", which implies that she views SENCOS as more able to create health-promoting educational settings compared to the teachers. Thus, although she positions the teacher as central, she also positions herself as superior regarding competence.

Moreover, this excerpt implicitly delineates the professional domain of teachers in the context of student health, which here encompasses teaching, assessment, and emotional support. The SENCO's statements suggest a distributed responsibility model, in which teachers are not just educators, but are also integral to the broader support structure that enables student health, thus challenging any strictly academic-only perception of their role.

Towards the end of the interview, the SENCO returns to discussing the importance of teachers in student health work. In the excerpt below, the teacher is yet again positioned as central, but without clearly positioning the teacher as competent in such work.

You can remove a teacher and it has great consequences. Remove a school nurse or a school counsellor or a SENCO and, well, yes, in the long run you will notice the consequences. But remove a teacher and there will be consequences within two minutes.

This statement directly positions teachers as being the most immediately impactful professionals within the school context. By emphasizing the immediacy of the consequences of teacher removal, teachers are positioned as central and indispensable figures in the day-to-day functioning of the school. This role is not explicitly connected to student health but rather to their direct involvement with the students. However, based on the previous statement from the same SENCO, it is likely that she is implicitly referring to student health work.

The contrasting mention of other professionals—school nurses, counsellors, and SENCOS—implies that although their contributions are valuable, they are perceived as having a less immediate or visible impact. This reflects an implicit hierarchy of roles, positioning teachers as the most critical actors in maintaining the school's continuity, while the contributions of other staff are seen as supplementary or with primarily long-term value. This reflects an interactionist view of roles as being not inherently fixed, but rather context-dependent. In the classroom or during teaching hours, the roles of teachers take precedence, due to their frequent direct interactions with students. The reference to other professionals' long-term impact acknowledges their value in terms of broader systemic student health and support, but highlights the differentiation of roles within the professional domain.

The principal in School A expressed frustration regarding the teachers having progressed to different extents in their work with student health. She stressed that student health is not only the responsibility of the SHT and when asked what the teachers' responsibility is, she answers:

I think it's important to work a lot on considering the groups you have in front of you—not thinking, "Now I need to fit this group into my course," but rather, "This is the course we have, but these are also the young people sitting here. What are their different needs? What do they require? How do I need to explain things?" (Principal, School A)

The principal demonstrates a standpoint where the role of the teacher is not static but must be adapted based on the students they are teaching. The quote suggests that the principal does not see the role of the teacher as simply delivering a fixed curriculum, but instead, they view their role as negotiable and responsive to the needs of the students. Stating that "*It's not about fitting*

the group into the course, but rather recognizing the students in the room and adapting to their needs.” reflects the notion that an individual’s role is influenced by context. Teachers are positioned as a flexible and student-centred educator, rather than a rigid instructor.

However, teachers are still positioned as ambiguously competent since the principal goes on by stating that she has had to “have conversations with teachers about this” and try to guide them by asking “Could you work with this area of the curriculum in a different way?” and “Could you test the students’ knowledge in alternative ways?”. She explains that some teachers have a more health-promoting mindset whereas others do not.

Another example of the positioning of teachers as central and ambiguously competent comes from a principal who, early in the interview, spoke about teaching as being part of working with student health. In particular, he underscored the importance of “high-quality teaching” as part of student health work. When asked what that entails, he referred to the following seven aspects identified by the Swedish School Inspectorate: structure and clarity, high expectations, teacher support, variation, adjustments, inclusion, and participation. He continued as follows:

If you plan your teaching this way, the students will feel a greater sense of participation, more belonging, maybe more manageability, and I think that is part of working with student health. (Principal, School B)

This principal positioned teachers as potentially competent, provided that they perform high-quality teaching. The created role extends beyond subject instruction, to include fostering a positive and inclusive environment that supports students’ emotional and social needs. By emphasizing a sense of “participation”, “belonging”, and “manageability”, the principal suggests that effective teaching incorporates aspects of student health work, particularly through the creation of supportive classroom atmospheres. Herein, student health is intertwined with classroom management and pedagogical planning.

The principal positions teachers as facilitators of well-being through their curriculum design and engagement strategies. In the principal’s narrative, effective teaching fosters student well-being, suggesting that student health work occurs not only through separate interventions or via the SHT, but is also embedded in everyday interactions and the learning environment. By framing the teaching process as a contributor to “manageability”, the principal promotes the narrative that student health can be supported by creating manageable, participatory, and inclusive spaces where students feel capable and engaged.

Discussion

This study was conducted to explore how teachers are positioned by other professional actors within the context of student health work, as well as the roles that teachers are assigned within these narratives. The findings reveal two contrasting positions: teachers are positioned as subordinate and marginalized, yet also as central and ambiguously competent. The roles assigned to teachers through this positioning are those of the “less competent help seeker” and the “potentially competent health provider”. These findings both align with and diverge from previous research, offering nuanced insights and implications for school practice.

The analysis demonstrated a recurring pattern in which teachers were positioned as subordinate to the SHT professionals, with frequent questioning or undermining of teachers’ competence in student health work. Both principals and SHT professionals often discussed student health from their own professional vantage points, and thereby indirectly positioned teachers. This indirect positioning, in which teachers were portrayed as needing guidance or “help” from SHT, reinforces a hierarchy with SHT professionals viewed as more knowledgeable and competent in addressing student health. This positioning and role assigning occurred almost exclusively within the narratives of the school nurses and school councillors. This might be due to their education and training contributing to different conceptualizations of health. From a biomedical and pathogenic perspective, teachers may be

perceived as lacking the necessary competence to engage in student health work, leading to their marginalization. However, within a salutogenic or holistic framework, as well as health and learning understood as interrelated, teachers can be considered competent in supporting student well-being. This perspective may also account for the tendency of principals and SENCOs to position teachers as more central and somewhat competent in student health work compared to school nurses and counsellors, as their conceptualizations of health differ.

These findings resonate with previous reports that have emphasized that teachers often feel ill-equipped to handle student health issues, and perceive them as being outside their professional domain (Tamburrino *et al.*, 2020; Askeff-Williams and Cefai, 2014; Mazzer and Rickwood, 2015). SHT professionals and principals in our present study often positioned teachers as needing support, guidance, or intervention from the SHT, reinforcing the idea that teachers are less competent in this domain. This is consistent with the findings of O'Reilly *et al.* (2018), who highlight that student health is often framed as external to teachers' primary responsibilities.

The narratives in the present study also reflect findings by Hylander and Guvå (2017), who describe tensions between teachers and SHT professionals arising due to role ambiguities. Instances of SHT professionals stepping into teaching-related responsibilities—such as delivering lessons or writing additional adjustments—illustrate the fluidity and contestation of professional boundaries. Although these actions may fill gaps in student support, they also challenge the boundaries of teachers' professional domains, implicitly positioning them as less capable or unavailable to fulfil these responsibilities. While such role fluidity highlights the shared goal of supporting student well-being, it also risks marginalizing teachers and eroding their confidence in their own professional agency.

In contrast, the present analysis also revealed the less common tendency to position teachers as central to student health work. In this narrative, teachers were described as being potentially competent, since health is integrated with their role related to learning and classroom management.

This finding reflects previous reports that emphasize teachers' unique role in fostering student well-being through their daily interactions and classroom practices (Hammerin and Basic, 2024; Maelan *et al.*, 2018). Similarly, the present narratives highlighted teachers as the primary point of contact for students, and as having responsibilities extending beyond instruction to include emotional and social support. A SENCO described teachers as the “nave” of student health work, which aligns with previous research recognizing teachers' critical influences on both academic and non-academic aspects of student well-being (Kostenius and Lundqvist, 2022). Similarly, a principal highlighted that “high-quality teaching” was integral to student health, linking effective pedagogy with the fulfilment of students' emotional and social needs.

However, even when teachers were positioned as central, their competence was ambiguously framed. These findings echo the ambivalence reported in previous research. While some educators feel confident addressing student health issues (Hammerin and Basic, 2024), others find it challenging to balance these responsibilities with their instructional roles (Willis *et al.*, 2019). While their central role is acknowledged, teachers' ability to successfully navigate student health challenges is often viewed as contingent on external support or specific pedagogical frameworks. This ambivalence reflects a tension between recognition of teachers' unique position to influence student well-being, and doubts about their capacity to independently address health-related issues. This tension reflects a broader debate about whether student health should be viewed as an extension of teaching, or as a distinct domain requiring external expertise.

A key contrast between the previous studies and the current material lies in how teachers' competence is framed. Douwes *et al.* (2024) and White and LaBelle (2019) largely depict teachers as active agents in student mental health, even if their engagement varies. In roles such as the Guardian or the Empathic Listener, teachers take on responsibilities that extend beyond academic duties, demonstrating deep involvement in students' well-being. The current study

material, however, often portrays teachers as either marginal figures or gatekeepers rather than direct agents of mental health support. They are described as reliant on the SHT for guidance, positioned as needing help rather than as competent professionals in their own right. This aligns with the positioning of teachers as “indirectly subordinate and marginalized,” where their role is seen as secondary to that of specialized student health professionals.

Another notable distinction is the perceived boundaries between professional roles. In [White and LaBelle's \(2019\)](#) study, teachers such as the Referrer maintain clear professional limits by directing students to mental health services rather than engaging personally. The current study however, suggests that these boundaries are sometimes blurred, as seen in the example of the school nurse taking over traditionally teacher-driven tasks like writing additional adjustments for students. This reflects a fluid negotiation of roles, where student health professionals sometimes assume responsibilities typically associated with teaching, reinforcing the marginalization of teachers in student health work.

Moreover, the principal's emphasis on high-quality teaching as a component of student health work suggests that teachers' roles extend beyond traditional academic instruction. This perspective aligns with the notion that effective pedagogy—through structure, clarity, and inclusion—contributes to student well-being. While this perspective positions teachers as integral to student health work, it does so with the caveat that not all teachers are equally prepared for or competent in fulfilling this role. This conditional framing aligns with the concept of teachers as “potentially competent health providers,” a role that acknowledges their importance while simultaneously suggesting that their efficacy in supporting student health depends on the quality of their teaching.

The context of the school is crucial for the development of student health promotion and the positioning of teachers. People's understanding of concepts, such as student health or teacher role, are created through interaction with others within the same context ([Blumer, 1969](#)). This understanding in turn affects their actions as well as their view of others ([Blumer, 1969](#)). The principals from both schools express a desire for enhanced student health work. They also appear to advocate for a comprehensive perspective on the educational mission and interprofessional cooperation, both of which are considered essential for effective student health work ([Hylander and Skott, 2020](#)). Given their key role in shaping and supporting the intersection between teaching and student health ([Skott, 2022](#)), it is likely that the schools' student health competencies will develop, potentially leading to a shift in the positioning of teachers within this framework.

It is also necessary to acknowledge the limitations of the study and suggest new research avenues. One limitation may be the uneven distribution of participants from each school. From School A, two principals and one school counsellor participated. The remaining six participants were from School B. This paper is based on qualitative data drawn from in-depth interviews with a relatively small number of participants. For that reason, care and critical reflection should be taken in transferring the findings reported here to other contexts.

The limitations of the study notwithstanding, the themes emerging from the data alongside the explanations developed in the discussion relate to universal aspects of student health practices and may therefore be valid in other, similar contexts. Generalization is not intended by this study; rather, its strength lies in the insights gained from the in-depth, qualitative analysis of rich data. The present contribution to the development of new knowledge has raised questions that can be explored in future research. For example, how can teachers and the Student Health Services successfully collaborate to promote student health? The research field could also benefit from similar studies conducted in other countries, since legislation and policy regarding student health promotion in schools differ between countries.

Overall, the present findings revealed several important implications for school practice.

Clarifying professional boundaries and roles

The results indicated that the actors had difficulty directly positioning the teachers in student health promotion and articulating their role. Role ambiguity is a source of tension, consistent

with previous research (Hylander and Guvå, 2017). Student health promotion could benefit from principals encouraging explicit dialogues about the respective roles of teachers and SHT professionals, and ensure that collaboration enhances teachers' agency rather than undermining it.

Strengthening teacher competence in student health

The results indicate that teachers are positioned as subordinate and in need of support in working with student health. While the present findings confirm previous reports of teachers' need for support (Mazzer and Rickwood, 2015), they also highlight the potential effects of pedagogical practices as health-promoting strategies. Professional development should not only address health-specific issues but also emphasize the integration of well-being into everyday teaching, such as didactics and classroom management.

Empowering teachers as key stakeholders in student health

Several actors position the teacher as central in student health promotion which support the view that teachers are central to student health work (Maelan et al., 2018). To empower teachers, principals can involve them in planning and decision-making processes related to health strategies, recognizing their unique insights and contributions.

Reframing student health as an integrated pedagogical practice

The results indicate that principals recognize the intersection between learning and student health. The emphasis on high-quality teaching as a factor supporting student health offers a practical pathway for schools. Teachers should be supported in creating inclusive, participatory, and structured classrooms that inherently promote well-being. This reframing reduces the perception of health work as an additional burden, and instead integrates it into core teaching practices.

Conclusion

This study contributes to elucidating the complex and sometimes contradictory positioning of teachers in student health work. While teachers are often marginalized and perceived as subordinate, they are also recognized as being central and pivotal to fostering student well-being. These findings align with and expand upon previous research, underscoring the importance of clarifying roles, supporting teacher competence, and reframing student health as an integrated pedagogical practice. By addressing these challenges, schools can harness teachers' full potential as both educators and advocates for student health, ultimately creating a more cohesive and supportive environment for student success.

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