Effect of Stress on the Health of Indigenous and Non-Indigenous Teenagers

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Stress is a physiological and psychological response to demands that a person perceives as challenging, threatening, or difficult to control. The original essay asks whether Indigenous or non-Indigenous teenagers are more affected and discusses bullying, migration, cultural change, substance use, and suicide risk. That comparison requires major clarification. “Indigenous” does not mean simply native-born, and “non-Indigenous” does not mean immigrant. Indigenous peoples are culturally and politically distinct communities with ancestral relationships to land, languages, governance, and collective rights. Non-Indigenous teenagers include immigrants and nonimmigrants from many backgrounds. There is no responsible universal conclusion that one of these enormous groups experiences more stress. Stress varies according to exposure, resources, discrimination, family support, culture, community, and structural conditions. The useful question is which stressors and protective factors affect particular groups and how services can respond without stigma.

What Is Stress?

Stress begins when the brain evaluates a demand and mobilizes systems needed to respond. The sympathetic nervous system can increase heart rate, breathing, alertness, and energy availability. The hypothalamic–pituitary–adrenal axis releases hormones including cortisol. In the short term, these responses can support performance, escape, concentration, or adaptation. Stress before an examination or competition may be uncomfortable while helping the person prepare.

Problems arise when stress is intense, repeated, unpredictable, or continues without adequate recovery. Chronic activation can interfere with sleep, mood, immune function, attention, relationships, and health behavior. The effect depends not only on the event but on whether the teenager has control, safety, trusted support, and ways to recover.

Adolescence as a Developmental Period

Adolescence involves physical maturation, identity development, increased independence, changing peer relationships, and decisions about education and future work. The brain systems involved in reward, emotion, planning, and self-regulation continue developing. Teenagers are not irrational by nature; they are learning to make decisions under new social and biological conditions.

Stress may come from school demands, family conflict, finances, discrimination, unsafe communities, illness, caregiving, social media, relationships, bullying, or uncertainty about the future. Adults

sometimes dismiss these pressures because they differ from adult responsibilities. For the adolescent, belonging and peer evaluation can have profound consequences.

Physical Effects of Stress

Short-term stress can cause headache, muscle tension, stomach discomfort, sweating, rapid heartbeat, or difficulty sleeping. Persistent stress may contribute to fatigue, pain, disrupted appetite, reduced concentration, and worsening of existing conditions. It is inaccurate to state that stress alone directly causes every case of diabetes, high blood pressure, or weakened immunity. Chronic stress can influence risk through hormonal, inflammatory, behavioral, and social pathways, but disease develops through multiple factors.

Teenagers may cope through physical activity, talking, music, spirituality, cultural practice, or problem-solving. Others may use alcohol, nicotine, drugs, self-harm, aggression, overwork, withdrawal, or disordered eating. These behaviors should be addressed without treating them as proof of bad character. They often signal distress and require safer alternatives and attention to the underlying condition.

Psychological Effects

Stress can produce worry, irritability, sadness, restlessness, anger, difficulty concentrating, or a feeling of being overwhelmed. These reactions do not automatically constitute a mental disorder. Depression, anxiety, trauma-related conditions, and substance-use disorders require assessment according to symptoms, duration, impairment, and risk. Persistent hopelessness, loss of interest, major functional decline, or thoughts of death deserve timely professional attention.

Suicidal behavior should never be described as an inevitable response of a racial or cultural group. It reflects complex interaction among distress, trauma, access to lethal means, discrimination, mental illness, substance use, social isolation, and protective relationships. Asking directly and compassionately about suicide can support safety; it does not create the thought.

Indigenous Identity and Historical Context

Indigenous teenagers belong to diverse nations and communities with different languages, traditions, histories, and living conditions. Population statistics should not erase that diversity. In the United States, the terms American Indian and Alaska Native cover hundreds of federally recognized tribes as well as other Indigenous identities. In Canada, First Nations, Inuit, and Métis peoples have distinct histories. Similar diversity exists among Indigenous peoples in Australia, New Zealand, Latin America, Asia, Africa, and the Pacific.

Many communities have experienced colonization, land dispossession, forced relocation, suppression of language and religion, residential or boarding schools, family separation, and discriminatory systems. These events can affect present health through intergenerational trauma, economic inequality, institutional mistrust, and ongoing racism. Historical context is not an argument that Indigenous youth are damaged by culture. Indigenous culture, community, language, land relationships, and identity can be powerful sources of resilience.

Current Stressors Affecting Indigenous Teenagers

Stressors may include discrimination, underfunded services, geographic isolation, housing problems, exposure to violence, loss of community members, limited access to culturally safe care, and conflict between school systems and community identity. Some rural communities face long travel for mental-health services, while urban Indigenous youth may experience disconnection or invisibility. These conditions are structural and should not be attributed to ethnicity itself.

CDC's 2023 Youth Risk Behavior Survey used an expanded sample of American Indian and Alaska Native high school students. It found important disparities in some substance-use, violence, and suicide-related outcomes while also identifying adult caretaking, parental monitoring, and school connectedness as protective factors (Everett Jones et al., 2024). Such data should guide support rather than portray every Indigenous student as high risk.

Protective Factors in Indigenous Communities

Protective factors include connection with caring adults, cultural identity, Native language, community participation, spirituality, traditional knowledge, peer support, and belief in a meaningful future. A literature review of American Indian and Alaska Native adolescent health identifies family connectedness, community support, cultural continuity, and positive school relationships among important strengths (Henson et al., 2017).

Programs are more likely to succeed when communities lead their design and when Indigenous knowledge is treated as evidence rather than decoration. Importing a generic intervention without local authority can repeat patterns of control. Tribal sovereignty, consent, data governance, and community interpretation matter in research and service delivery.

Stress Among Non-Indigenous Teenagers

Non-Indigenous youth are not one comparison group with a shared experience. They may be affluent or poor, majority or minority, immigrant or nonimmigrant, rural or urban, disabled or nondisabled, and exposed to very different levels of safety and support. Some face racism, gender-based violence, homophobia, family instability, war, poverty, or chronic illness. Others have substantial protection.

A valid study must define the population precisely. Comparing Indigenous youth with all non-Indigenous youth can reveal broad disparities but may conceal socioeconomic conditions and differences among communities. The comparison should not imply that non-Indigenous teenagers are unaffected or that their experiences are the standard against which others are measured.

Immigrant and Refugee Teenagers

The original essay shifts from non-Indigenous youth to immigrant children and assumes that most immigrants live away from family. That is inaccurate. Many migrate with parents or extended family, while unaccompanied minors represent a specific group. Immigrant teenagers may experience language change, discrimination, interrupted schooling, insecure legal status, separation, acculturation pressure, or fear for relatives. Refugees may have experienced war, persecution, displacement, or loss before arrival.

Migration can also bring safety, educational opportunity, family reunification, and strong community networks. Maintaining heritage language and culture can support identity. Services should not treat cultural adaptation as abandoning the original culture. School interpretation, anti-bullying measures, legal support, and family engagement can reduce stress.

Bullying and Harassment

Bullying involves repeated aggression and a power imbalance and may be physical, verbal, relational, or digital. Harassment based on race, ethnicity, gender identity, sexual orientation, disability, religion, or immigration status can create chronic vigilance and undermine school belonging. The original essay cites research on gender-minority social stress, which is relevant as an example of how stigmatization affects youth but does not directly establish differences between Indigenous and non-Indigenous teenagers.

Schools should provide confidential reporting, consistent investigation, protection from retaliation, and support for targeted students. Teaching victims to be more resilient without changing the environment transfers responsibility to those harmed. Bystanders and institutional norms help sustain or interrupt bullying.

School Connectedness

School connectedness is the belief that adults and peers care about a student and their learning. CDC data associate connectedness with lower prevalence of several risk outcomes among high school students. Among American Indian and Alaska Native students in the 2023 survey, higher connectedness and adult engagement were associated with lower prevalence of selected substance-use, emotional, suicide-risk, and violence measures (Everett Jones et al., 2024).

Connectedness grows when students experience fair discipline, relevant curriculum, supportive adults, safety, extracurricular participation, and genuine respect for identity. A school cannot create belonging through a slogan while allowing racist mascots, mispronounced names, exclusion, or unequal punishment.

Family and Caregiver Support

Family cohesion can be protective, as the original essay suggests, but family structure should not be romanticized or used to blame caregivers. Indigenous families have experienced policies that deliberately separated children from parents and communities. Present stress can be intensified by poverty, illness, incarceration, or service gaps. Supporting families may require material assistance as well as parenting information.

Caring adults provide monitoring, practical support, boundaries, cultural guidance, and a place to discuss problems. Youth without safe parental support may find protection through extended family, elders, teachers, coaches, mentors, or community organizations.

Rural and Urban Contexts

The original essay assumes Indigenous teenagers live in rural communities. Many do, but many live in towns and cities. Rural settings may provide community continuity and land connection while facing distance from healthcare, broadband limitations, transport barriers, and fewer anonymous services. Urban youth may have access to more services but encounter cultural isolation, discrimination, or difficulty locating Indigenous-specific support.

Programs should be adapted to place. Telehealth can improve access but requires privacy, Internet, and culturally competent professionals. Local schools and clinics should establish relationships with tribal and urban Indian organizations rather than assume one model fits all.

Racism and Minority Stress

Repeated discrimination can create anticipatory stress, anger, withdrawal, sleep disturbance, and reduced trust. Minority-stress frameworks explain how stigma-related events and expectations add to ordinary developmental stress. The effects are not evidence of weakness. They are responses to environments that repeatedly threaten dignity or safety.

Intervention should target both the individual and the system. Counseling may help a teenager process experiences, while policy and accountability are needed to reduce discriminatory treatment. Teaching coping without addressing racism leaves the source intact.

Substance Use as Coping

Some teenagers use alcohol, nicotine, cannabis, or other substances to reduce distress temporarily or gain peer acceptance. Short-term relief can reinforce use while creating health, legal, family, or academic problems. Prevention messages that rely only on fear may fail when the substance serves a powerful social or emotional function.

Effective responses assess trauma, mental health, access, peer context, and cultural strengths. Treatment should be confidential within legal limits, nonjudgmental, and developmentally appropriate. Indigenous-led prevention can integrate community values and healing practices with evidence-based care.

Research Limitations

Comparative research faces problems of small samples, racial misclassification, suppressed data, and grouping distinct tribes or nations together. Surveys often exclude youth not attending school, who may have different levels of risk. Cross-sectional data show associations at one time and cannot establish that one factor caused another. Self-report is valuable but affected by recall, trust, and question wording.

Researchers should involve communities in question selection, interpretation, ownership, and publication. Deficit-focused research can produce a repeated picture of crisis while ignoring resilience and successful local programs. Both harm and strength should be measured.

What Schools and Health Services Can Do

Schools can strengthen connectedness, employ culturally representative staff, include accurate Indigenous history and contemporary life, prevent harassment, and create confidential routes to support. Health services can screen for stress, depression, trauma, substance use, and safety without assuming diagnosis from identity. Care should be culturally safe and linked with community resources.

Suicide prevention requires trained gatekeepers, crisis response, continuity after emergencies, safe storage of lethal means, and long-term community investment. Public articles should direct readers to verified local emergency and crisis services rather than list numbers that may not apply in every country.

Conclusion

Stress affects all teenagers, but exposure and protection are distributed unequally. It is not accurate to conclude universally that Indigenous teenagers are less stressed than non-Indigenous teenagers or that non-Indigenous youth are immigrants living away from family. Indigenous youth may face ongoing effects of colonization, discrimination, service inequity, and historical trauma, while drawing strength from culture, language, family, land, community, and sovereignty. Immigrant, refugee, gender-minority, and other non-Indigenous teenagers may face different forms of exclusion and transition. Comparisons should define populations carefully and avoid ranking suffering. The most useful evidence identifies modifiable stressors and protective factors. Caring adults, family engagement, cultural connection, school belonging, equitable services, and safe communities can protect health. Responsibility lies not only with teenagers learning to cope but with institutions reducing the conditions that generate chronic stress.

References

Everett Jones, S., Satter, D. E., Reece, J., et al. (2024). Adult caretaker engagement and school connectedness and association with substance use, emotional well-being, suicide risk, and violence among American Indian or Alaska Native high school students—United States, 2023. *MMWR Supplements, 73*(4).

Henson, M., Sabo, S., Trujillo, A., & Teufel-Shone, N. (2017). Identifying protective factors to promote health in American Indian and Alaska Native adolescents: A literature review. *Journal of Primary Prevention, 38*(1–2), 5–26.

Reisner, S. L., Greytak, E. A., Parsons, J. T., & Ybarra, M. L. (2015). Gender minority social stress in adolescence: Disparities in adolescent bullying and substance use by gender identity. *Journal of Sex Research, 52*(3), 243–256.

Wexler, L., Chandler, M., Gone, J. P., Cwik, M., Kirmayer, L. J., LaFromboise, T., Brockie, T., O'Keefe, V., Walkup, J., & Allen, J. (2015). Advancing suicide prevention research with rural American Indian and Alaska Native populations. *American Journal of Public Health, 105*(5), 891–899.