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Health-related maternal practices of immigrant Muslim mothers in the United States

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ABSTRACT

This study examines maternal practices of immigrant Muslim mothers in the United States to understand how they share their health values with their American Muslim adolescent daughters. The maternal practices were studied in the context of each family's and especially the mother's religious and cultural values. Further, the influence of religion, culture of origin and acculturation on immigrant Muslim mothers' values and thus maternal practices in the United States was examined. Using a criterion sampling strategy, 11 immigrant Muslim mothers and their American Muslim adolescent daughters who were born and raised in the United States were interviewed. The interviews were transcribed verbatim, coded, and analysed using a phenomenological approach. Mothers in this study showed that their health values were shaped by Islam, culture origin and the acculturation factor. Mothers shared health values with their adolescent daughters by being available, monitoring their health behaviours, engaging in healthy communication with them, and modelling healthy behaviours. Understanding these maternal factors will help create effective health education to support immigrant Muslim mothers serve as a protective factor for their adolescent daughters, help them make healthy choices, and follow healthy behaviours within Muslim communities in the United States.

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The mother-daughter relationship starts at the birth of the daughter and normally continues throughout the rest of the mother's life. This relationship encompasses transformations related to the changing developmental needs of the mother and the daughter (Biederman, Nichols, & Durham, 2010). When the daughter is in the early childhood stage, the mother provides care, support, and love to her child. During adolescence, the mother continues providing love and advice, but her parenting style would change; she should listen and understand the daughter's needs to help her make choices and take on the responsibilities of young adulthood (Steinberg & Silk, 2002).

In Islam mothers have a very special place. They are respected and recognized in the family. A Muslim mother plays a major role in the daily life of her family members by

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protecting and taking care of them physically, mentally, and spiritually (Oh, 2010). Her care and support continues throughout her entire lifespan and adapts to the developmental needs of her children. A Muslim mother is not only responsible for reproduction and generational continuity, but she also is responsible to educate her children about Islamic values, faithfulness, good behaviour and moralities. For immigrant Muslim mothers and their American Muslim adolescent daughters in the United States, maternal relationships are shaped by different ecologies: the culture of origin of the mother, Islam, and the new dominant culture (Al-jayyousi, Nazarinia Roy, & Al-Salim, 2014).

Given the nature of motherhood in Islam, we are interested in examining how maternal practices can be a protective factor for American Muslim adolescent daughters raised in the United States despite the diverse ecologies influencing this relationship. The main purpose of this study is to examine how maternal practices (availability, monitoring, communication, and behaviour modelling) can influence the health behaviour (eating behaviour, drug use, and physical activity) of American Muslim adolescent girls. The mother-daughter relationship was studied in the context of each family's and especially the mother's religious and cultural values. Further, the influence of religion, culture of origin and acculturation on immigrant Muslim mothers' values and thus maternal practices in the United States was examined.

Literature review

Adolescent girls in the United States report less healthy behaviours than boys (Centers for Disease Control and Prevention, 2004). They would eat fewer fruits and vegetables and consume less milk, diet more often, have more disordered eating behaviours, and exercise less than boys (Mackey & La Greca, 2007). Regarding ethnicity, Mackey and La Greca found that Black adolescents follow unhealthier eating behaviour when compared to both White and Latino adolescents. Also, in the physical activity domain, Black adolescent girls are less physically active, are less likely to engage in physical activities, and are more likely to report sedentary activities like watching television than are White girls (Dowda et al., 2004).

Adolescents' health status is influenced by their many social relationships, including their relationships with their mothers (Scelza, 2011). Researchers have documented the important and integral role that mothers play in shaping and influencing attitudes and behaviours of adolescents regarding health issues (Berge et al., 2015; Branstetter, Furman, & Cottrell, 2009; Motl, Dishman, Saunders, Dowda, & Pate, 2007).

Health-related maternal practices

Parental availability means parents share different activities with their children and spend time with them to provide an opportunity for the parents to share experiences with their children and know their interests (Pearson, Muller, & Frisco, 2006). When a mother is available and attends sporting events with her daughter, the daughter is influenced to be physically active and be more involved in similar events (Ransdell, Dratt, Kennedy, O'Neill, & DeVoe, 2001). Sharing meals with adolescents is another aspect of availability. Eating meals as a family has been associated with good intake of fruits and vegetables, dairy products, and basic vitamins and minerals along with decreased soft drink consumption (Neumark-Sztainer, Hannan, Story, Croll, & Perry, 2003).

Parental monitoring is an aspect of parental control that refers to parental awareness of where the child is, with whom he/she is, and what he/she is doing (Herman, Dornbusch, Herron, & Herting, 1997). The mother usually has the role of 'food gatekeeper' and has a considerable impact on controlling the dietary behaviour of family members. She often has control over what food is available in the house, and she also sets the food rules for her children (Quick et al., 2018). As a result, she can limit the availability of unhealthy foods and can try to provide her daughter and family with healthy meals. Maternal monitoring is also associated with low rates of substance use. Adolescent girls who are not well monitored by their mothers have higher rates of substance use (Branstetter et al., 2009) and low parental control projected adolescent smoking initiation (Blokland, Hale, Meeus, & Engels, 2007).

Mother-daughter health communication includes the transmission of both facts and values (Reis, 1996). Mothers often present facts to their daughters, including explanations of the physical and physiological changes that occur during adolescence. Adolescents who receive anti-smoking messages from their parents, such as those regarding health risks associated with smoking, will have lower rates of smoking initiation (Henriksen & Jackson, 1998).

Mothers and daughters may rely mainly on values to communicate with each other about different health issues including drugs, nutrition, and exercise (Reis, 1996). Parents can develop in their adolescents a set of motivations for responsible behaviour by including consideration of the social, familial, and moral negative consequences of irresponsible behaviour (Jaccard & Dittus, 2000). African American adolescent girls who reported that their mothers had discussed issues related to morality of premarital sex were more likely to delay having sex than girls with mothers who did not discuss these issues with their daughters (Usher-Seriki, Bynum, & Callands, 2008).

How communication occurs between the mother and her daughter is another important factor that may influence the girl's health behaviour (Gore, Frederick, & Ramkissoon, 2018). A mother should have the knowledge, be willing to listen, talk openly and freely, and try to understand the feelings and needs of her daughter. Children from families with open and positive communications are less likely to become involved with drugs than are children from families in which this kind of communication is not found. A mother who is flexible and uses an interactive style when communicating about health with her adolescent will probably help her daughter have great knowledge about the negative consequences of unhealthy behaviours, and thus avoid risky behaviours (Lefkowitz, 2000).

Another maternal factor that may relate positively to health behaviour of adolescent girls is maternal modelling of the health behaviour. Parental modelling is defined as 'a process of observational learning in which the behavior of the parent acts as a stimulus for similar behavior in his or her child' (Tibbs et al., 2001, p. 536). Adolescent girls are influenced by their mother's drug use behaviour, so that girls who have mothers who smoke will most probably smoke cigarettes and even use marijuana themselves (Brook, Rubenstone, Zhang, & Brook, 2012).

In order to understand the dynamics of the mother-daughter relationship and maternal practices and how they may influence the health behaviour of the adolescent daughter, it is appropriate to explore the mother's values and traditions since they play important roles in shaping maternal practices that impact health status. Studying the cultural and environmental contexts in which maternal relationship is embedded will help clarify the crucial role mothers play in influencing their daughter's health behaviour.

Maternal values of health

During adolescence children are exposed to value messages from their parents more than any other stage of development because they will be busy exploring the culture and society around them resulting in identity commitment and autonomy achievement. Through the mother-daughter relationship and the maternal practices of availability, monitoring, communication, and modelling, mothers share their health values with their daughters, which may contribute to their daughter's health behaviours. However, mothers vary in their health values. For example, African American women are more satisfied with their weight as compared to White American women, even if they are overweight because they believe they are more attractive when they gain weight (Flynn & Fitzgibbon, 1998). African American women may also place higher value on rest than being physically active during leisure time (Airhihenbuwa, Kumanyika, Agrus, & Lowe, 1995). As a result, their adolescent daughters may accept these unhealthy values as their own personal values, and follow unhealthy behaviours.

Muslims in the United States

Islam is the fastest growing religion in the United States comprised of 7 million Muslims from different ethnic origins (Council on American-Islamic Relations, 2003). The majority are immigrants from other countries, such as Jordan, Syria, Palestine, Egypt, Lebanon, Iraq, Pakistan, India, and Bangladesh (Smith, 2003).

In a literature review about the health of Arab Americans in the United States (Abulezam, El-Sayed, & Galea, 2018), the authors reported that the prevalence of smoking among Arab Americans is ranging from 6% to 45% in some states. The authors also claimed that according to the National Health Interview Survey, the prevalence of diabetes ranged from 4.8% to 23%, hypertension is 13.4%, heart disease is 7.1%, and hypercholesterolemia ranged from 24.6% to 44.8% among Arab Americans.

According to Ahmed, Abu-Ras, and Arfken (2014), American Muslim adolescents face many of the same health risks as their non-Muslim peers. In their national study of college students, tobacco usage among Muslim college students was 37%, a similar rate compared to non-Muslim college students (41%). Among U.S. Muslim college students, 50% had consumed tobacco in some form, including cigarettes and waterpipes, and more than half (56%) of tobacco users reported their first experience was prior to 18 years of age.

In addition, 47% of Muslim college students reported having consumed alcohol in the past year and 24% had used marijuana, with no significant difference by gender (Abu-Ras, Ahmed, & Arfken, 2010). Muslim students reporting marijuana use indicated that 52% had first used marijuana prior to turning 18. These findings provide evidence of the risks facing immigrant Muslim teens in the U.S.

Health values in Islam

Good health is considered a great blessing in Islam (Bakhtiar, 2007). Islamic health values that encourage good health and give guidance for Muslims are clear in both Qur'an and Hadith. The Qur'an recommends eating fruits, vegetables, and honey because of their nutritious value and their advantage in preventing and curing different diseases:

Then let man look at his food ... And produce from there corn. And grapes and plants to eat. And olives and dates ... And fruits and herbage. (Qur'an, 80: 24–32)

Then to eat from all the fruits of the earth, ... : Then from their bodies comes a drink (honey) of varying colors, wherein is healing for you. (Qur'an, 16: 69)

The Qur'an advises people to select the best foods and enjoy them: 'Eat of the good things that we have provided for you' (Qur'an, 7:160). Moderation is emphasized and the Qur'an forbids excessive eating which leads to obesity and other medical problems: 'Eat and drink, but do not be excessive' (Qur'an, 7:30).

Prohibited actions and behaviours in the Qur'an that lead to negative consequences on health include drinking alcohol, eating pork and premarital sex:

O you who believe? Intoxicants and gambling ... are undesirable of Satan's tricks avoid such undesirable things, so that you may prosper. (Qur'an, 5: 91)

Forbidden to you are: dead meat, blood, the flesh of swine. (Qur'an, 5:3)

And do not do adultery: Verily, it is shameful deed and an act evil, opening the road to many other evils. (Qur'an, 17: 32)

Hadith prohibits also excessive eating and provides guidelines for healthy eating behaviours:

We Muslim people do not eat until we get hungry, and we do not get full. (Al jazairi, 1976, p. 116)

The worst thing that a human being does is eating till he is full, it is enough to eat small amount of food that provides the person with the needed energy, and if he is not doing this, then one third for the food, one third for liquids, and one third for air. (Al jazairi, 1976, p. 118)

Finally, Islam encourages Muslims to teach their children different sports to make them strong and stay physically active. Hadith says: 'Teach your children swimming and throwing arrows' (Muslim, 2007).

Maternal practices in Islam

In order to pass these Islamic values on to their children, Muslim mothers discipline their children and teach them how to listen and respect adults' opinion and advice, and especially the wisdom and knowledge of older adults. On the other hand, mothers should be close to their children. They should listen and understand their needs and be characterized by 'affection and generosity' toward them. Schleifer (1986) defined the generosity of Muslim mother as 'willingness to give one's time to one's children or to share knowledge or to give assistance when needed' (p. 48). Hadith reported:

Narrated Abu Hurairah: Set your children's eyes on piety; whoever wants to can purge disobedience from his child. (At-Tabarani, 2008)

Narrated Anas: Be generous to your children, and excel in teaching them the best of conduct. (Ibn Majah, 2007)

Narrated Jabir Ibn Samrah: That one of you disciplines his child is better for him than if he gives charity everyday half a sa (cubic measure) to a poor person. (At-Tabarani, 2008)

Immigrant Muslim mothers in the United States are influenced by these Islamic values and practices regarding parenting, yet there is diversity among Muslim mothers' values.

Part of this diversity can be explained by the way these mothers practiced Islam in their country of origin.

Culture of origin, Muslim mothers' values and maternal practices

Islam is not only a religion; it also is a way of life for Muslims. In Islamic countries, it is hard to separate and differentiate religious values from the culture. But there is diversity in these religious values from one country to another that is reflected by diversity in practicing Islam. This cultural diversity comes from the different interpretations of Qur'an and Hadith. On one hand, Muslims have the general laws, or sharia, which can be found in both Qur'an and Hadith. These laws are fixed and cannot change. On the other hand, there is fiqh. These are the laws 'deduced' from sharia. They are specific and changeable according to circumstances in which they are applied (Philips, 1988). In Islam there are different schools of fiqh, and each one has its own way of interpreting Qur'an and Hadith. In addition, there are fatwas, 'religious rulings and statements that are collectively agreed upon by the authorized religious leaders of the Muslim country' (Isalm & Johnson, 2003, p. 321). They are issued to deal with behaviours that have not been explicitly mentioned in the Qur'an or Hadith and are to be followed by all Muslims.

However, Islamic countries are different in what school of fiqh and fatwas they are following. For example, different Muslim countries have different fatwas regarding smoking. World Health Organization-EMRO reported that religious scholars in Egypt announced that smoking is considered a sin and is prohibited because of the harm it may cause to the individual's health, like alcohol and other drugs (2001; cited in Isalm & Johnson, 2003, p. 321). This fatwa is not followed by all Muslim countries. As a result, we may see diversity in Muslim mother's health values regarding smoking and different parenting values about this health issue. A Muslim mother from Egypt may consider smoking a sin and prohibit her daughter from smoking because it is prohibited by religion. Another Muslim mother may prohibit her daughter from smoking because of the negative consequences of this behaviour on her health. In other cultures, Muslim mothers may prohibit their daughters from smoking because it is not common for girls and women to smoke in that culture as it is considered unfeminine behaviour. Yet, we may also find other Muslim mothers who smoke and so influence or even encourage their daughters to smoke.

Muslim mothers may share health values with their daughters by following different maternal practices, which are greatly shaped by their cultures. For example, although listening to and respecting a mother's advice by her children is emphasized within all Muslim cultures, in some cultures Muslim mothers expect their daughters to highly respect their values and opinions, not to talk back, and to obey and accept these values as their own personal values. Other Muslim mothers may expect their daughters to respect their values, but at the same time allow polite communication, expression of feelings and the sharing of their opinions with them.

Immigrant Muslim mothers depend largely on what they perceive as their religious and cultural values in their parenting practices (Maiter & George, 2003). They struggle to pass these values on to their children despite the challenges they may face. Yet, we cannot understand the influence these values have on the maternal practices in isolation from the new culture; American culture.

Acculturation, values, and Muslim maternal practices in the United States

Within the new environment Muslim mothers may show variety and flexibility in what values they can accept from the new culture and in parenting their children. These mothers may believe that they can accept values from the new culture unless they are prohibited by Islam or contradictory of Islamic values. In addition, they may try new ways of parenting and different strategies to understand their children's needs (Maiter & George, 2003). Mothers try to be good role models for their daughters in practicing Islam and cultural customs, be involved in their children's lives, and keep healthy communication with them (Ross-Sheriff, Tirmazi, & Walsh, 2007).

Currently, there is no research exploring the influence of acculturation on immigrant Muslim mothers' health values and behaviours. Immigrant Latino mothers in the United States reported the negative impact of acculturation on their diet, eating behaviour, and physical activity (Sussner, Lindsay, Greaney, & Peterson, 2008). In addition, research about health risks among Chinese and Korean immigrant women in the United States reported higher smoking rates in women who have become more acculturated (Shelley et al., 2004) and this rate can be three times higher than those living in their country of origin (Ma et al., 2004; Song et al., 2004).

Acculturation influences mothers' parenting behaviours regarding different health issues. Immigrant mothers are likely to be busier in the new culture than in their country of origin, because they may have jobs and spend long hours outside their houses. Even though they want to continue preparing traditional meals for their families, they may change their meal routines because they are not able to prepare three traditional meals each day (Sussner et al., 2008). These mothers also may stop following some behaviours that indicate good parenting in their culture of origin. For example, they may stop encouraging their children to 'finish their plates' which indicates good parenting in their culture of origin because they do not want them to suffer from becoming overweight or obese.

Understanding the health and well-being of children and adolescents has been neglected and the scarcity of empirical research in adolescent health presents a gap (Patton et al., 2016). Immigrant Muslim mothers are a rapidly growing population in the United States for which there seems to be little or no information about their health values and parenting practices. The purpose of this study is to fill the gap in the scholarly literature regarding how mothers protect American Muslim girls from health risks. This research study will shed light on the maternal factors and practices among immigrant Muslim mothers that may influence their daughters' health behaviour. The findings would aid in planning for family-based interventions to improve maternal relationships and adolescent's health behaviours in the Muslim community in the United States. Specifically, the study is guided by the following research question: What are immigrant Muslim mothers' health-related mothering practices with their American Muslim adolescent daughters?

Methods

A phenomenological approach was employed in this qualitative study to examine maternal practices regarding health behaviours of immigrant Muslim mothers in the United States. This approach emphasizes capturing and describing how people directly

experience a phenomenon: 'how they perceive it, describe it, feel about it, judge it, remember it, make sense of it, and talk about it with others' (Patton, 2002, p. 104).

Data collection

After receiving permission from the Institutional Review Board at Kansas State University, a criterion sampling strategy was used. The criteria included: (1) Mothers who were Arab immigrants from the Middle East (Jordan, Palestine, Lebanon, Syria, Egypt, Kuwait, and Iraq), (2) who had lived in the United States for at least 12 years, and (3) their adolescent daughters aged 12–18 years old who were born and raised in the United States. Flyers inviting participation were posted in three cities in the Midwest of the United States in Islamic Community Centers and businesses and were sent through e-mail lists to Muslim community members. Snowball sampling followed by asking participants to share the study information with those they knew who fit the criteria. Eleven immigrant Muslim mothers and their 11 American Muslim adolescent daughters in the United States participated. (See [Table 1](#) for a description of the sample: *M* stands for Mothers and *D* for daughters and each is given a number to protect confidentiality.)

After the mothers signed consent forms for themselves and their daughters, in-depth, face-to-face, semi-structured interviews were conducted by the first author with the mothers and daughters separately in an Islamic Center, the public library, or in the participants' homes. The interview questions originally were written in English and then translated to Arabic. Participants were given the choice to use either language. Two mothers answered the questions in English using a few Arabic expressions from time to time. All the daughters' interviews were conducted in English. Each interview lasted approximately 45 min and was digitally audio-recorded.

Data analyses

In qualitative research, the researcher is the measurement tool. Therefore, during the analysis process, we explicitly identified our biases, expectations, and reactions. Although we attempted to set our biases and expectations aside, we acknowledge that we described what we saw through our own experiences of mothering and the meanings they generated in our awareness. Here we briefly describe our life experiences and perspectives related to this study.

Inductive qualitative analyses involved discovering the themes in the interviews of the mothers and daughters. Data were analysed using constant comparative techniques. Pieces of data were compared for similarities and differences (Corbin & Strauss, 2008). Each transcript was coded and new themes were added to the codebook as they emerged. Constant comparisons were conducted to differentiate one theme from another and to identify dimensions of each theme. With each addition of new data, themes were added and modified as needed. Finally, the themes were combined into a coherent textural description of the phenomenon. The authors worked independently to analyse the data to help in the verification process. We read through the transcripts and identified the common themes separately, then came together to discuss the results and came to consensus regarding the themes and categories.

Table 1. Demographics for immigrant Muslim mothers and age of their American Muslim adolescent daughters.

Dyad #	Mother's Age	Education	Job	Residency in the US	Language Used with Mother	Country of origin	Daughter's Age
1	41	9th grade	Part time	17 years	Arabic	Jordan	17
2	50	Three years in college	No	27 years	Arabic and English	Syria	17
3	42	Bachelor Degree	Full time	15 years	English	Syria	14
4	48	Diploma Two years	No	19 years	Arabic	Palestine	17
5	35	9th grade	No	17 years	Arabic	Syria	16
6	43	Diploma Two years	No	19 years	Arabic	Syria	16
7	34	Diploma Two years	No	16 years	Arabic	Kuwait	14
8	49	Two Bachelor degrees	Full time	28 years	English	Egypt	18
9	42	Master degree	Full time	20 years	Arabic and English	Lebanon	18
10	40	Diploma Two years	No	19 years	Arabic	Jordan	17
11	50	Diploma Two years	No	20 years	Arabic	Iraq	14

Results

The analysis process revealed that immigrant Muslim mothers share their health values shaped by religion, culture, and acculturation with their American Muslim adolescent daughters through being available, directly communicating, monitoring, and modelling behaviour. Each of these is described below and is supported by exemplar quotes (in italics) from the mothers and daughters.

Religion influences immigrant Muslim mothers' health values

Mothers described religion as an important factor in shaping their health values regarding eating behaviour, physical activity, and drug use. All the mothers mentioned that they did not eat pork because it was prohibited by religion and that was like a 'red line' for them and their families. The 'red line' expression (indigenous term) was used by a majority of the mothers to indicate that these are boundaries mainly shaped by religion that should not be crossed by any family member.

The majority of the mothers mentioned that religious values made them conscious consumers; they read labels on any product they bought. As participant #108 described, 'I am one of these people that, you know, spends some time in supermarkets reading labels because there is something in there that I don't believe should be included in my diet.' Another mother (#110) said that she usually buys products from Middle Eastern stores to be sure that they were free from gelatin and pork: 'They can't, even my daughters, sometimes they like jello. If they want it, I make jello from the Arabic store. They have no gelatin.'

Immigrant Muslim mothers in this study showed variety in their values regarding physical activity and how these values were influenced by Islam. For active mothers, it was clear

that the dressing while exercising or swimming was an issue for them because they wanted to follow the religious values when it comes to modest dressing. Participant #107 mentioned, 'If I am dressed properly in swimming, I don't care about mixed pools.' Another participant (#108) bought DVDs to exercise at home, because, as her daughter mentioned, she did not want to look different from other Americans with the scarf she wears. In addition, exercising in gym clubs with boys or men and swimming in mixed pools was another issue. One participant (#102) explained that she used to swim when they had their own pool in a previous house, but now she stopped because they were living in a house, which shares a pool with the entire neighbourhood. Finally, Some mothers mentioned that they were exercising because this will help them stay healthy and protect them from different diseases. However, the prophet's teachings were included in their explanations when I asked them about the influence of religion on their physical activity.

All the mothers mentioned that they did not drink alcohol because this was forbidden in Islam and they were raised on these religious values. Regarding the smoking behaviour, all the mothers mentioned that they didn't smoke cigarettes, except for one who was a heavy smoker and another mother who used to smoke but she quit. However, they were different in explaining the influence of religion in shaping these health values. Some mothers said they did not smoke because it was forbidden by Islam. Other mothers mentioned that they did not smoke because religion prohibited any bad behaviour that might hurt their health. 'They said in our religion, anything that hurts you is not good. It is haram' (#110). 'Haram' is a religious expression used to indicate that this behaviour is forbidden by religion. This variety in the mothers' religious values was shaped by how these mothers interpreted the Qur'an and Hadith, which was shaped by their countries of origin. 'Religion has a huge influence I think on the way I behave, but religion is practiced in my mind with a of little bit of cultural twist' (#108).

Culture of origin influences immigrant Muslim mothers' health values

Mothers in this study showed variety in how they were influenced by their countries of origin. Some mothers explained that the influence of their culture of origin on their health values was the dominant. Other mothers mentioned that it was hard to separate the influence of their cultures of origin from religion on their health values. The overlap between culture of origin and religion was clear when the mothers talked about their values regarding smoking behaviour. One mother (#110) who was from Jordan explained that she learned that smoking was forbidden in Islam from her family back home: 'My brother in Jordan was like, "You never touch it, it is haram." He is Emam (a religious scholar), but you know, um, it is haram.' Two participants mentioned that although they were not smokers, if I gave them a cigarette or cigar they would smoke, because they explained that smoking behaviour was not forbidden by religion according to their values.

Various countries from the Middle East have different cultures and so there are diverse cultural values regarding health behaviours. An immigrant Muslim mother from Lebanon (#109) described herself as a 'health freak' and she mentioned that she cared a lot about her appearance. She tried to eat healthy all the time, she went to gym, but she used argile because it was 'in style' in her home country. On the other hand, immigrant Muslim mothers from Iraq, Kuwait and Jordan showed conservative health values and behaviours.

These mothers mentioned that in these countries there were cultural barriers that limited the healthy choices women could make. In between these liberal and conservative extremes, there were mothers from Egypt, Syria, and Palestine. These mothers also showed that they were influenced by their countries of origin and that they were moderate in their health values.

Ten mothers from this sample mentioned that they were still cooking traditional meals from their cultures of origin for their families in the United States. Some mothers talked about how they tried to prepare the three meals for the family and sit at the table for the three meals.

Mothers in the current study showed that their physical activity was greatly influenced by their cultures of origin. Immigrant Muslim mothers practiced what was accepted by their culture of origin to stay active. It was also clear that some mothers ended up practicing what was common for women to do to stay active in their culture of origin. For example, one mother (#109) mentioned that she started going to the gym on the weekends. Even though she had a gym club at work that she could use every day, she did not, because, as she explained:

Yeah, I mean not every day. For example, at work they want you to go to the gym every day. We have gym at work. But, I think I don't want to blame anybody, but we were not raised as in this culture.

The women's use or nonuse of drug was influenced by their cultures of origin. Some participants (N = 3) mentioned that they were using shisha or argile (water pipes) because it was a common behaviour for women in their countries of origin. Participant #109 explained, 'I mean, the shisha has to do with the culture back home.'

For those mothers who believed that smoking was not forbidden by religion, it was clear that they did not smoke because it was not accepted in their culture of origin for women to smoke; two mothers told me that they can smoke if I gave them cigars or cigarettes. 'But my dad was smoking. It is not prohibited by religion. When it comes to me, if I had the choice at that time, I may smoke' (#106).

Acculturation in the U.S. influences immigrant Muslim mothers' health values

Immigrant Muslim mothers made some adjustments and changes in their health values when they moved to the U.S. They showed that their health values were shaped more by their own goals and desires more than by religion and or culture of origin. Six mothers mentioned that they were more religious in the United States than when they were in their country of origin. Two mothers said that they were not 'very religious' and another two participants talked about how they were in the middle and they did not like extremes. Another mother (#102) mentioned how in the new culture she learned about the 'real Islam,' separated from the influence of cultural values and traditions.

Some mothers mentioned that culture of origin was still shaping their values in the new culture. They talked about how sometimes the cultural values were blended with the religious values and it was hard to separate them. On the other hand, immigrant Muslim mothers mentioned that although they were still following some cultural values from back home, over time they were trying to leave out some of these values to survive with their daughters in the new culture.

Muslim mothers described that they have value conflicts with their daughters. The majority of the mothers mentioned that the value conflict was mostly about cultural values and the difference between the old and the new cultures. There was rarely any religious value conflict between these mothers and their daughters, because as these mothers explained that they started teaching their daughters about religious values when they were very young. All mothers mentioned that they did not face any conflict with their daughters about eating behaviour and drug use. However, some mothers talked about conflicts regarding their daughters' physical activity. In addition, some mothers talked about how sometimes their daughters might not like to eat the traditional family meals they cooked, and they wanted to eat junk foods or something else. These mothers showed that they would be flexible and cook different meals for them.

All the mothers mentioned that they did not change their religious values regarding eating behaviour in the new culture even over time. For example, all of them indicated that they still did not eat pork, ham, or gelatin. 'For religion, of course it is religion. Religion is religion. We can't change. We don't eat ham. We don't drink alcohol. We still wear hijab' (#101). They said these values were 'red lines' for them and for their families, because they could not change them.

Living in the United States imposes different values and some environmental factors that may have led Immigrant Muslim mothers to make changes or adjustments on their cultural values. In addition, the different life style they may follow in the new culture may challenge them to make these changes. Some mothers said that they could not prepare three meals a day at home for their families, because they were busy and they had jobs. Six mothers mentioned that they were eating in restaurants because they were busy and they could not cook the three meals for their families or because they simply made it a habit. Only three mothers said that they ate junk foods and they usually would feel bad after this, because they knew it was not healthy.

Mothers showed variety in the influence of the new culture on their health values. Two mothers mentioned that they were not as healthy as they were in their country of origin. Three mothers mentioned that they were not as active as in their home country. On the other hand, some participants mentioned that they were following healthier behaviours in the United States compared to their behaviours back home regarding eating behaviour and physical activity. The majority of the mothers in this sample explained that the new culture increased their awareness about healthy behaviours regarding healthy eating behaviour, physical activity, and smoking. All of the mothers, except for one, mentioned that they were not smokers before coming to the United States and they did not smoke after they came here. The only mother who was smoking mentioned that the new culture had a positive influence on her smoking behaviour because of the laws and the bans the government had for those who smoked. Participants also felt that one of the factors that was encouraging them to follow healthy behaviours was the freedom they have in the United States.

Maternal availability

Mothers in this study explained that the more they were available, the more they shared their health values with their daughters by 'preparing healthy family meals together,' 'going to the gym together,' or even 'doing shisha' (water pipes) together. Whether they

were working outside the home or not, they tried to be available for their daughters after school.

Even when I do work, I make a point to be available when she comes home, or not be gone for too long after work. I always worked outside the house, but I am always available whenever kids are back home from school. (M8)

My mom, I think she, um, she tries to be at home a lot and to make dinner every day and have us sit down and eat dinner together ... And she'll tell me what she wants to do with me and be doing that together. (D8)

Only one mother felt she was spending enough time with her daughter. The other participants felt that because of work or being busy with other family members, they wanted to increase their time with the girls. The daughters also had busy schedules, especially on school days and sometimes the girls were not willing to spend time with family.

For [daughter's name], she is spending long time in studying. It is taking time, I mean, every day. But, in general she will sit with me and with her dad in the evenings, not for long time, and not always. This generation is different, not like us; we used to sit for long hours with our family in the evenings. (M1)

She is definitely available. I don't know that I utilize the time that she is willing to give, and we are both busy, I mean, I am now working, I started school last year and she is working, so we both are gone during the day. She is definitely there for me if I need her. (D8)

Mothers indicated that it was not only the amount of time that was important in parenting their daughters, it was also the quality of time they spent together. They mentioned that whenever they were spending time with their daughters they would try to share and talk about their values, especially the religious ones. 'I feel like a squeaking wheel, "You have to do this and you have to do that". And so, I always remind them, "If I am not watching you, somebody else [God] is watching you."' (M9)

Mother-daughter communication

Immigrant Muslim mothers varied in how they handled communication with their daughters. All of them talked to their daughters about their religious health values and some participants talked about cultural values, health facts, and about the consequences of following a certain health behaviour.

Mothers talked to their daughters about health information and the negative health consequences of following certain behaviours. Some talked to their daughters about how they should 'eat more vegetables and fruits,' 'stop eating junk foods,' and 'watch how much she eats' to avoid negative health consequences now and later in life. Some mothers talked to their daughters about how they should 'be active and practice different sports.' A few also talked about the negative consequences of smoking and other drug use.

Um, we do talk like what will happen if you smoke, how you will start smoking. Like one of your friends will ask you to try it. "It will make you happy." I will explain to her what will happen if you try once, what will happen after that. (M3)

Daughters also described health communication with their mothers regarding their eating behaviour and physical activity. One participant mentioned that she would ask her mother's opinion about what sport she should do. Another participant mentioned that

they would talk about how they needed to ‘follow healthier eating behavior’ than what they were following.

Some daughters initiated discussion of health facts about their mothers’ behaviour:

Sometimes, like when she thinks like, “Oh my God, I need to go on diet,” then I will explain things to her about calories and diet, and talk about exercising ... Yeah, she takes it and sees this as something valuable. She will say, “Okay, I learned something about fitness.” (D6)

Mothers provided daughters with advice and warned them about behaviours that contradicted with Islam and/or harmed their health status. One mother explained:

We always have to look at it this way. When I make the food we always remember, you know, Islam told us not to waste ... and when you eat leave one third for your food, and one third for your drink, and leave an empty spot for breath. (M2)

Several daughters talked about how their mothers would discuss religious health values with them and how they perceived this positively because they believed it was for their benefit:

Her opinion is more driven by like what Allah and the Prophet says. So, if she has anything to say, like, in the conversation if we’re talking about one thing, it will turn into another thing about Islam, and then another thing about Islam. So, it is not exactly like she is stubborn, but she is so fixed on what’s right and she is trying to get me into the right thing. (D6)

Immigrant Muslim mothers showed that they use several styles of communication to share their health values with their daughters. A majority of the mothers described using reasoning and explanation when sharing their religious health values with their daughters to help them understand and accept these values. Mothers mentioned that they could not merely prohibit behaviours that contradicted with their religious and cultural values, because they also needed to explain and answer their daughters’ questions regarding these health values.

M4: ‘If you keep saying for everything, “haram, haram, haram, haram” to ... a daughter raised here in this country, you should tell them why you are saying this. You should explain to them, and they should be convinced.’ As an example, she described how she convinced her daughter to avoid eating pork:

I explain, you know, pigs eat dirt and defecate and eat it, and all this goes to your body and blood. God wants us to stay healthy, and so this is not healthy. And they will be like, “Yuck, yuck, Mommy. This is disgusting!” This is, this is how I make it easier on them. I cannot say only, “This is haram,” and that’s all. So, they relate haram to unhealthy.

Some mothers talked about how they reacted when their daughters argued with them or were not convinced of their values. Mothers mentioned that they might get angry with their daughters, but they would think about what they asked for and might return to them to discuss the issue. Two participants mentioned that they would tell their daughters their opinion regarding a behaviour, and if they were not convinced, then they will let them experiment. For example, M4 said:

Sometimes she comes and tells me she wants to do something, and I tell her “No.” But I will let her do it. Then she will come back to me and be like, “Mama, you are right. I was wrong.” So, in my opinion, the mother should not force her values. She should let her daughter

experiment, and then she is free. If she succeeds, so she is. If not, she will come back and say, “Mama, I was wrong.”

Some daughters indicated they had a positive perception of the communication methods used by their mothers. They mentioned that their mothers usually answered their questions and gave them explanations.

I like about her, I like is, when I ask her a question, she may end up explaining all what I want to know ... I will share with her, she will listen to me and she will enjoy listening ... I feel free to discuss what I want with my mom. (D4)

Some mothers talked about how the daughters’ generation was different and how they asked about everything and they always wanted explanations.

Yeah ... in order to be able to share your values with your daughter and give them advice, you can’t just sit and just tell them. You should give them the advice in fun environment, they will accept the advice more in fun or relaxing times. (M11)

However, a few mothers struggled to share their values with their daughters. One mother (M7) described the problems she had communicating with her daughter. She said, ‘I will invite her to restaurants. I will take her to the cinema. We go shopping together by ourselves. I thought she will talk to me, but she will stay silent.’ Others talked about how their daughters did not like sharing their feelings with them. They preferred spending time by themselves and in their rooms, had secrets, and liked sharing with friends more than with their mothers.

Only one daughter (D7) mentioned that she was not communicating a lot with her mom because she did not have anything important to talk about:

I don’t talk to her every day and we don’t really talk big talk. Like, I talk to her as like, “Do you want more water?” I don’t talk to her, like conversations about stuff ... There is nothing really to talk about, like, there is nothing really happening to me to talk about with her.

Monitoring their daughters’ health behaviours

Monitoring was a parenting practice emphasized by all the mothers. They believed that this would help protect the girls from unhealthy behaviours or those that contradicted with their religious and cultural values. Therefore, they created clear rules and determined which were flexible and which were not.

These mothers created family rules to indicate red lines regarding ‘time spent on computers and cell phones,’ ‘eating in restaurants,’ ‘eating junk foods,’ ‘exercising,’ and ‘dressing for swimming and track.’ For example, D4 said, ‘And sometimes she, whenever I will be on my phone when I go home, first thing I do, I turn it off so I don’t want to be on it too much.’ M9 mentioned, ‘I always like them, like not to sit down at the TV. ‘Go ride the bicycle.’ They have to be active.’

M1 mentioned,

I will smell their clothes, when they go out in evening even with Arab friends, you know, I am still afraid, I trust them, but I am not sure 100%. The evil is there and the bad friends also play a role.

A few mothers in this study explained that when their daughters did not adopt their religious values, then they would impose them on their daughters. M8 said,

She knows there are few things that I am definitely not cool with, and she knows that and we kind of reach almost an understanding that there are some things that they are not even for discussion. So just deal with it. This is the rule and this is how it is gonna go.

Some daughters described that their mothers were not open-minded and imposed their values on them, and they would give their opinions whatever the daughters did. Two participants mentioned that they did not like how their mothers communicated with them, because they would get mad if they did not agree. D5 said, 'Sometimes it kind of depends on her mood. Either she will be mad, or she will tell me what to do to make it better. It kind depends on her mood.'

In contrast, some daughters described the flexibility of their mothers and how they would communicate when they had different opinions. D4 described, 'She will sit me down, and we talk about the differences between here and there, and she will say I may have been raised this way, but you have been raised here this way.' This daughter showed how her mother understood the new culture's values and also understood that her daughter was influenced by these values because she was raised in the United States and not in her country of origin.

Modelling health behaviours

Participants in this study talked about how the mothers tried to model different health behaviours for their daughters. They did this in both indirect/covert ways and direct/overt ways that included instruction and explanation of their behaviours.

M11 reported indirect modelling: 'Sometimes you don't say things or force them, but when you do [something], they will follow. So, this is very important. It is like a model for them.' Some mothers tried to covertly model healthy behaviours, to eat healthy, be active, and avoid smoking and drug use.

A majority of the mothers described preparing healthy meals for their families. They ate vegetables and fruits, avoided eating fast foods or at restaurants, and directly encouraged their daughters to follow the same behaviour. Mothers who walked often took their daughters with them. M1 mentioned, 'In most cases I will go with her. Sometimes the other daughters will come with us. We will walk.' Others took their daughters with them to the gym.

Three mothers modelled behaviours that would be considered unhealthy and encouraged their daughters to follow this behaviour because it was part of their culture of origin. 'I sometimes argile (use a water pipe) with my daughter [laugh]. It is in style. I want to make her busy' (M4).

Five mothers mentioned that they thought their daughters were accepting of them as their role models of different health behaviours. M9 mentioned: 'Yeah, I think, yes, they always tell me, "You are our model, Mama."' as Four mothers described that their daughter did not see them as positive models when it comes to health behaviour.

She makes many comments on my weight. She always tells me, "Get on a diet. Get on a diet." And I am just ignoring. "Stop smoking," and I am just ignoring. "Go and do more activity," and I am just ignoring. So, she will say, "I am tired of you and your lifestyle is not good." She wants me to change, maybe she will be happy if she sees that I am really changing to the way she loves to see me. (M7)

Ten daughters described positive perceptions of their mothers modelling health behaviours.

Umm, you know she works out. She likes to go to the gym a lot. She cooks healthy meals for the family, and I like this. I go with her to the gym. She doesn't smoke, and I don't like smoking. (D10)

D9 talked about how she was greatly influenced by her mother's health values: 'I mean, it does very much influence [me]. Just because, like, growing up through my whole life, it has been like, "You have to eat healthy. You have to take care of your body."' Another two participants mentioned that their mothers were their models even though they knew that they were following unhealthy behaviours, such as having shisha together or eating unhealthy foods.

One mother mentioned that although her daughter was not accepting of her as a role model now, later she would. 'It is now she might not, because her mind is not, like, developed. I think in the future she will be influenced [by what she sees me do]' (M10).

On the other hand, three daughters indicated that they would not consider their mothers as their models regarding their health behaviour because they were exhibiting unhealthy behaviours. For example, D7 said that her mother could not be her model because she was eating unhealthy, was not active, and was a smoker: 'No, when she eats, she can eat. What she does, she can do. That has nothing to do with me. I eat completely different from what she eats.'

The research question examining immigrant Muslim mothers' maternal practices regarding health behaviours was addressed and major themes, subthemes, and the textural description were provided. Direct quotes from the participants were also included to enhance the validity of the themes and subthemes.

Discussion

Koenig, McCullough, and Larson (2001) emphasized that women who are considered religious by praying and attending religious services usually perceived religion as important in their lives. They also mentioned that women 'depend on religion as a coping [support]. Thus it is possible that religious ... practices are more deeply ingrained into the social and psychological lives of women and therefore confer greater health benefits' (2001; cited in Marks, 2006, p. 607). This endorses the importance of religion as a context to help understand and explain what is happening in the lives of the immigrant Muslim women in the current study.

In this study, immigrant Muslim mothers in the United States explained that religion greatly shaped their health values regarding eating behaviour, physical activity, and drug use. For example, there are direct laws in the Qur'an prohibiting eating pork and drinking alcohol. All the immigrant Muslim mothers in this study reported that they consciously followed these religious values. They saw them as 'red lines' for themselves and their families. However, when there was no direct or explicit law regarding a behaviour, then the mother's culture of origin shaped her health values.

Immigrant mothers from different cultures in the United States try to keep their cultural values and practice their cultural traditions to help stay connected with their extended families in home country and give them the healthy sense of belonging to the group. Research with South Asian Muslim women in Canada and the United States found that culture of origin was a major factor in shaping these mothers' values (e.g.

Maiter & George, 2003). In this study, culture of origin shaped immigrant Muslim mother's health values: the majority cooked traditional meals for their daughters, they practiced what was common for women to do to stay active in their culture of origin, and they followed the smoking customs accepted by their old culture.

Countries like Lebanon and Egypt are known as liberal countries regarding women rights, gender issues and in the freedom they give to women (Moghadam, 2003). On the other hand, countries like Jordan and some Gulf countries (e.g. Iraq) are known as conservative regarding women rights. In between, we may see other countries from the Middle East, such as Syria and Palestine, who are considered moderate regarding these rights. Immigrant Muslim mothers' health values in this study ranged from conservative to liberal. Conservative mothers said that they did not swim, they walked to stay active and or they chose gym clubs for women only, and they did not smoke because it was not accepted by their culture for women to smoke. Liberal mothers swam (even in mixed pools), went to mixed gym clubs, and smoked shisha because it was accepted in their country of origin. In between the extremes, were the moderate who might swim if they had their own pool, might go to mixed gym clubs or exercise at home, and might smoke shisha.

Contrary to what some researchers found about the challenges Muslim families might face following religious values in the United States (e.g. Ross-Sheriff et al., 2007), the mothers in this study indicated that they were free to follow their religious values in the United States and never felt pushed to change them. However, some talked about how they left out some culture of origin values over time and made some changes in the new culture because it was hard to keep practicing their original health behaviours.

Sussner et al. (2008) found that immigrant Latino mothers in the United States perceived the impact of acculturation on their eating behaviour and physical activity negatively. They felt that they were following healthier behaviours in their countries of origin than in the United States. Some immigrant Muslim mothers in this study felt they were eating unhealthy food and they were not active in the new culture. On the other hand, some felt that they were healthier in the United States than back home; they were eating healthy and they were more active because they had choices and they were free to do whatever they wanted.

The explanation for these differences could be that those participants who kept their religious values, left out some of their (unhealthy) cultural values, and were more accepting to new values from the new culture, had the freedom to make more healthy choices than others. This would lead to a positive perception of the influence of the new culture on their values. On the contrary, mothers who retained culture of origin values (or made few changes) even when they contradicted with healthy behaviours and were less accepting to the health values from the new culture did not have the freedom to make healthy choices. Thus, they were more likely to have negative perception of the influence of the new culture on their health values.

The Muslim mothers in this study shared their health values in various ways with their adolescent daughters. These include direct/overt strategies of being available and engaging in healthy communication with them, as well as indirect/covert practices of monitoring the daughters' health behaviours and modelling healthy behaviours themselves.

Direct/overt strategies

Previous research about parenting practices of immigrant South Asian Muslim mothers in the United States found that religion and culture of origin greatly shaped the mothering of their daughters (Ross-Sheriff et al., 2007). Immigrant Arab Muslim mothers in this study mentioned that religion greatly shaped their parenting practices to their daughters; the majority felt they were more religious than in home country. Additively, some mothers mentioned that culture of origin shaped their parenting in the new culture and they talked about how sometimes the cultural values regarding parenting were blended with the religious values and it was hard to separate them. Smith (2003) described this as ‘over-protection’ of religious and cultural values by Muslim immigrants in the United States. He explained that a parent who might have been less religious in his/her native country might become more religious and more protective of culture of origin values to compensate for the differences between both cultures. These differences might be caused by coming from a culture in which the majority is Muslims to another culture where Muslims are considered minorities.

Hattar-Pollars and Meleis (1995), in their study about the parenting experiences of Jordanian immigrant women in California, mentioned that these mothers were struggling in parenting their adolescents in the new culture because it was their responsibility to share their cultural values with them. In addition, they were to make them active and successful members in the new culture. In this study, immigrant Muslim mothers explained that they understood the developmental and social changes their daughters faced during adolescence. They knew that girls in this age wanted to have more space than before, to spend more time by themselves, to be independent, to experiment, to spend long time doing homework, to find a job, and enjoy hanging out with friends more than with their families. Some mothers also talked about how their daughters were a different generation from theirs; they argued a lot, they wanted explanations and honest answers, and they wanted to be responsible. Others talked about the influence of technology and how this exposed the daughters to the whole world. So, these mothers were trying to help their daughters have a ‘bicultural identity,’ because they thought that this was necessary for healthy development.

Schleifer (1986) explained that mothers in Islam are characterized by a willingness to be close to their children, to share their knowledge, and be available to give assistance when needed. The mothers and daughters in our study emphasized the importance of maternal availability, which seems to set the foundation for the other strategies. Without spending quality time together with their daughters, communicating, monitoring, and modelling would not be effective. This notion is supported by previous research indicating that available mothers who attend sporting events and prepare healthy family meals enhance the physical activity and healthy eating behaviour of their adolescent daughters (Neumark-Sztainer et al., 2003; Ransdell et al., 2001).

While spending time with their daughters, mothers in the current study reported that they frequently *communicated* with them about their religious and cultural values regarding health behaviours. This occurred at different times and settings, but was described as especially effective when the daughters were relaxed and enjoying family moments. The mothers provided advice and warned their daughters about behaviours that contradicted with Islam or could harm their health.

Communication between mothers and their daughters was an important parental practice to share health values; and content and process are both important aspects when communicating with adolescents (Gore et al., 2018). In a descriptive study of African-American mother–child communication about drugs and health, Reis (1996) found that these mothers and their children depended on values to communicate about health behaviours with each other. For example, they warned them about taking any drugs in school or talking to anybody who sold drugs. They also warned them about the consequences of using drugs and how children would die from them. Similarly, mothers in this study talked about their religious and cultural values regarding different health behaviours with their daughters. They provided them with advice and warned them about following behaviours that contradicted with Islam or harmed their health.

Ross-Sheriff et al. (2007) reported that immigrant South Asian mothers used open communication and were good listeners who shared their values with their daughters. Similarly, a majority of the mothers in this study mentioned that, when sharing their religious values with their daughters, they used explanation to help them understand and accept these values.

Mother-daughter communication was also challenging and sometimes problematic for the mothers in this study. Although they tried different methods of communication and they tried to create an open environment for their daughters, sometimes they ended up forcing their values on them. This resulted in conflict. As a majority of mothers mentioned, however, this conflict was more about the cultural values than the religious ones. The mothers, therefore, tried to be flexible on some of their cultural values and allowed their daughters to adopt some behaviours from the new culture.

Indirect/covert strategies

Maiter and George (2003) found that immigrant South Asian mothers provided guidelines and set boundaries for their children in order to socialize them in the new culture and to help share their cultural values with them. In the current study, mothers described ‘family rules’ or ‘red lines’ regarding choosing friends, hanging out with friends, time of returning back home, going to cinema or theatres, using computers, using cell phones, texting messages to friends, eating in restaurants, eating junk foods, and dressing for swimming and track. ‘Family rules’ and ‘red lines’ were indigenous terms used by the mothers to point to the boundaries they gave their daughters in the new culture. These lines and rules were mainly shaped by religion and sometimes by culture of origin that mothers provided to make sure that their daughters would follow behaviours that matched their religious and cultural values and thus were safe and healthy.

Denby and Alford (1996) mentioned that this might be explained as ‘restrictive’ parenting practices; however, these mothers were following practices to be able to raise ‘Muslim’ and ‘American’ daughters in the United States. I believe immigrant Muslim mothers felt that by putting these family rules, which were mainly shaped by religion, and following the other maternal practices, it would be easy on their daughters to be convinced and accept their religious values. They also felt that this would help their daughters have the sense of belonging to the big group (the Muslim community), which they perceived as important for their daughters to have healthy development and enhance their self-confidence. Being Muslim mothers made them put high expectations for mothering their daughters, and

being immigrants added to these expectations because of their responsibility in front of their extended families in home country and the fear of being unable to raise Arab Muslim daughters.

Health behaviour modelling was another maternal factor that was examined in this study. Previous researchers reported that mothers could share their healthy or unhealthy values by modelling the health behaviour for their children (Brook et al., 2012). Immigrant Muslim mothers modelled various health behaviours. Some tried to be role models for healthy behaviours; they ate more vegetables and avoided eating junk foods or at restaurants, they tried to be active by walking or going to the gym, and they did not smoke. Other mothers modelled unhealthy behaviours by eating unhealthy, not being active, and smoking.

Our study has some limitations. The first limitation in this study could be from recruiting by snowball sampling technique. I interviewed mothers who were suggested to me by other participants and who, in some cases, were friends. These participants, since they were friends, might have similar religious and cultural values and that may have limited the diversity we aimed for among immigrant Muslim mothers. The second limitation was that I interviewed only Arab Muslim immigrant mothers from the Middle East because I was unable to recruit non-Arab Muslim mothers. Although the purpose of this qualitative study is the in-depth examination and understanding of the phenomenon (more than the generalization of the findings to other Muslim communities), interviewing only Arab Muslim immigrant mothers may limit applying the findings to other non-Arab Muslim communities.

The findings address some gaps in the literature regarding immigrant Muslim mothers' health values and maternal practices within a Muslim community in the United States, and the influence of the different ecologies surrounding these values and relationships. Findings and conclusions of my study should be treated as hypotheses for future testing rather than as definitive. In this study, we explored the positive parenting approaches and their influence on adolescent health behaviour. Future research should address the other negative parenting approaches including: parental behaviour control; coercive control; parental-over protection; parental dementedness; negative differential parenting; parental indulgence; authoritarian parenting; neglectful parenting; and physical parent discipline. In addition, addressing the family context, and investigating the link between different parenting approaches and adolescents' health behaviours should be examined with other health issues and behaviours (mental health, drinking, etc.). Finally, father involvement in parenting adolescents and their influence on adolescents' health behaviours should be explored.

Findings from this study can be helpful for family and health professionals who are working with mothers and their adolescent daughters in Muslim communities in the United States specifically and Muslim families in western cultures generally. In the area of family education, knowledge about these maternal factors can be used to educate mothers and enhance their skills to help their daughters engage in healthy behaviours. They can develop family-based interventions designed to foster a close relationship and understanding between parents and their children, enhance mother-child communication, enhance adolescents' perceptions of parental monitoring and, as a consequence, reduce their risky health behaviours.

In the public health area, the findings emphasize that mother's involvement should be part of any intervention implemented to promote the health of adolescents. This focus on

the mother-daughter dyad and on this relationship presents an important direction for programmes, policy and practice. The shift toward social determinants of health among young people means that the major threats to their health and well-being are progressively rooted in the everyday life.. This means that the search for protective factors must include an understanding of adolescents' social relationships and perceptions of connections to others within the family as they experience and live through the developmental changes of adolescence.

Third, professionals should understand that they cannot deal with immigrant Muslim mothers as a single entity. Some mothers showed that their health values were mainly shaped by religion and so their maternal practices to their daughters, other mothers showed that culture of origin greatly shaped their health values and also their maternal practices to their daughters. Others showed that they accepted values from the new culture and they made adjustments and changes on their cultural values.

Conclusion

This study will enrich the family field by adding to the literature and giving explanations for an important phenomenon: how mothers can be a protective factor for their adolescent daughters, help them make healthy choices and follow healthy behaviours within Muslim communities in the United States and in other Western cultures.

The findings will help explain how these maternal factors can work together to shape the adolescent daughter's health behaviour. Therapists and educators can gain a better understanding about these factors within a Muslim community and so know how to deal with these mothers and their American Muslim adolescent daughters.

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