

MOTHER-DAUGHTER RELATIONSHIPS WITHIN A MUSLIM COMMUNITY AND THE
INFLUENCE ON AMERICAN MUSLIM ADOLESCENT DAUGHTERS' HEALTH
BEHAVIOR

by

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B.S., Medical and Biological Analysis, University of Jordan, 1996
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AN ABSTRACT OF A DISSERTATION

submitted in partial fulfillment of the requirements for the degree

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College of Human Ecology

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Abstract

Immigrant Muslim mothers is 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. Approximately 4 million adolescents in the U.S. have Arab Muslim immigrant parents. The goal of this study is to understand how adolescent girls' health behaviors can be shaped and influenced by sociocultural factors especially the mother-daughter relationships and the influences of living in a Muslim community in the U.S. The immigrant Muslim mother's values (religious and cultural) that shape these relationships were examined. Next, the influence of the new dominant culture; the American culture on the mothers' values, maternal practices and thus the adolescent daughter's health behavior was addressed. Using criterion sampling strategy, eleven immigrant Muslim mothers and their American Muslim adolescent daughters (N=22) who were born and also raised in the United States were recruited and interviewed. The interviews were transcribed verbatim, coded, and analyzed following phenomenological research methods. Mothers in this study showed that their health values were shaped by Islam, culture origin and the acculturation factor. The majority of the mothers explained that they were more religious in the United States and some of them mentioned that they left out their culture of origin values and accept some values from the new dominant culture. Mothers in this sample explained that in order to share their values with their daughters, they needed to be close, supportive, open minded, good listeners to them. In addition, they followed different maternal practices such as: tried to be available, monitored their health behaviors, had healthy communication with them although there was imposing, and tried to model different health behaviors. However, the daughters' perception of the mothers' health values and maternal relationships was an important

factor in determining how these values and practices could shape the daughters' health behaviors. The results revealed that daughters who perceived that their mothers' values and practices were shaped by the three factors were more likely to follow healthy behaviors. A theoretical model was developed. Implications for family professionals and recommendations for future research are discussed.

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Dedication

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Chapter 1 - Introduction

*“When the peaks of our sky come together
My house will have a roof.” (Paul Eluard & Dignes de Vivre)*

In their book about the challenges of parenting Muslim teens in North America, Ekram & Beshir (2007) talked about their real experience in raising their teen daughters. They addressed real-life examples with their daughters. Hoda, one of the daughters, talked about how the style of dressing was one of the challenges she faced. Although it is not required in Islam that girls must wear a *hijab* (head cover) before puberty, Hoda began *hijab* before she was ten years old. She said:

“I committed myself to wear the hijab before I was even ten years old...but the most thing that I stood out in was my style of dressing. I liked a certain look that was called “the skater style”. Skaters wore big T-shirts, really baggy pants, sneakers, and caps.... That was my style between grade six until about grade ten. By the time I was in grade eleven, I was letting the skater style go and starting to dress in a more appropriate manner.... Finally, I took the decision to wear only skirts and no pants as my mother was urging me to do.” (p. 10).

Hoda and her mother is an example of how Muslim mothers in the United States may influence their adolescent daughters’ behaviors. It is clear how Hoda’s values regarding her style of dressing are at the end influenced by her mother’s values. The mother did not push, instead she let her daughter explore and choose the “skater style”. The exploration was from age 12-16 years old. During this time, the mother tried to communicate her values regarding dressing to her daughter. After that, in grade eleven, Hoda was able to make commitments and had her own personal values regarding the style of dressing which were greatly shaped by her mother’s values.

In Islam mothers have big influence on their children, especially their daughters. Both mothers and daughters value their relationship with each other. For immigrant Muslim mothers and their American Muslim adolescent daughters in the United States, this relationship is surrounded, influenced and shaped by different ecologies; culture of origin for the mother, religion, and the new dominant culture. Hoda struggled to find a balance between her religious values and the American values regarding her dressing style. Hoda's mother understood her daughter's needs during this critical stage of development and tried to have a positive, healthy relationship with her. As a result, the daughter perceived these values accurately and the mother was able to shape and influence her adolescent daughter's behavior.

Significance of Mother-Daughter Relationship

The mother-daughter relationship is exceptional. It is the relationship that starts from the birth of the daughter and continues through the mother's entire life. The mother is typically considered the nonstop source of love, support, and kindness to her daughter and she is the person who usually never expects rewards for the efforts. This relationship may encompass transformations depending on each person's stage of development, and the different needs of both the mother and the daughter (Kenemore & Spira, 1996). When the daughter is in the early childhood stage, the mother will provide care, support, and love to her child. During adolescence the mother will continue providing love and advice, but her parenting style must be different; she will try to be a good friend to her daughter by listening and understanding her needs. As the daughter moves to adulthood and the mother is in the stage of older adulthood, there is another transformation in the relationship so that the mother will often need the help, support, and love from her daughter who may be a mother at this stage of development.

Mothers play a basic and important role in raising children and socializing them as active members of the society. They usually spend more time with their children than fathers do (Collins & Russell, 1991). Mothers are more likely than are fathers to talk and transmit information to their children, and are more likely to talk with their daughters than their sons (Dutra, Miller, & Forehand, 1999; Miller, 1998). As a result, adolescents, especially adolescent girls, often like to be close to their mothers and feel relaxed talking to them about problems and other different issues (Steinberg & Silk, 2002). These aspects of mothering are not only crucial to daughter's definition of self and identity formation, but they also influence later grown-up behavior of the daughter.

The mother-daughter relationship is warm and intimate relationship. A mother may think of her daughter as if she has reproduced herself and the daughter sees that she is, somewhat, an extension of her mother (Chodorow, 1978). Girls in general are influenced by their relationships with others (Gilligan, 1982), and it is through the mother-daughter relationship that daughters may internalize their mothers' values and behaviors that may lead them to be like their mothers. Yet, it is central to this relationship that the mother not ignore the developmental needs of her daughter and not keep seeing her daughter's experience as a replication of her own. The mother-daughter relationship is not only about the domestic responsibilities and the common social roles to women; it also is about knowledge and shared experiences between the mother and her daughter which can lead to more confidence and self-awareness. In addition it may reflect the mutual interests around the academic and professional life (Kenemore & Spira, 1996).

Finally, the mother-daughter relationship is important for all women whatever their ethnicity, religion, or background. Understanding the dynamics of the mother-daughter

relationship may shed light on how women can be influenced by other women because this relationship may also influence the daughter's relationships outside her family (Abudi, 2011).

Purpose of the study

I am fascinated by how the mother-daughter relationship can be a protective factor for American Muslim adolescent girls raised by immigrant Muslim mothers in the United States despite all the ecologies influencing this relationship. The main purpose of this study is to examine how this relationship and maternal practices (availability, monitoring, communication, and behavior modeling) can influence the health behavior (eating behavior, drug use, and physical activity) of American Muslim adolescent girls. The mother-daughter relationship will be 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 will be examined.

I have always believed that motherhood is such a hard task and a big responsibility, but it is much harder to be a mother in a culture other than one's own culture; while one is an immigrant. I am a Muslim mother, originally from Palestine, of two daughters who will be raised in the United States. My mother is my role model for different social and health behaviors. I was so close to her and used to refer to her in different issues to ask her opinion and advice. Now, I am a mother, but in a culture different from the culture I have been raised in. So what kind of relationship I will have with my daughters? Can I raise them as my mother raised me? How can I share my religious and cultural values with them? Will that be possible in the new and different culture? And how the dominant new culture will influence and shape my relationship with my daughters?

After I had a master degree in community health focusing on adolescents' and women's health issues in the United States, I add to my concerns regarding motherhood other health concerns because raising healthy adolescent girls in the United States will not be an easy task. During this stage of development, adolescent girls are faced with concerns about: body image and eating habits, use and abuse of alcohol and drugs, sexually transmitted diseases and AIDS, unwanted pregnancy, rape, sexual harassment and violence. They are more susceptible to depression and are four times more likely to attempt to suicide than boys (Kenemore & Spira, 1996).

In order to answer my questions and concerns, I have decided to study the different health behaviors of American Muslim adolescent daughters in a family level and especially in the context of the mother-daughter relationship and mothering. So I entered a PhD program in family studies to research and dig more about these concerns. During my classes in this program, and especially theory classes, I start realizing that the mother's values and the daughter's perception and acceptance of these values are important factors in shaping this relationship. Then other questions rose to me about the factors shaping these values, especially for immigrant Muslim mothers in the United States. So I found that I need to address more contexts to understand this phenomenon. Religion, culture of origin, and acculturation are the factors that I am interested in researching about in this study.

I have such big dreams and hopes for my sweet hearts, so I find that I need to be prepared for their adolescence to help them live happily and healthy. Hopefully, the findings from this study will be of help for me and for other immigrant Muslim mothers in the United States specifically, and immigrant Muslim mothers in western societies generally.

Chapter 2 - Literature Review

This study aims to examine the relationship among immigrant Muslim mothers and their American Muslim adolescent daughters and the influence of this relationship on the health behavior of the daughter. The literature review begins by pointing to the significance of this stage of development; adolescence. Next, the literature regarding the influence of the mother-daughter relationship and maternal practices on the health behavior of adolescent girls is examined. The mother's values as a context to be able to understand the dynamic nature of this relationship is addressed. Then, the three contexts that shape and influence the values of immigrant Muslim mothers in the United States are highlighted; religion, country of origin, and acculturation. Finally, the theories that helped me organize the literature review and frame the research questions are reviewed.

Adolescence as a Stage of Development

During adolescence girls face physical, cognitive, identity, and social developmental changes (Steinberg & Silk, 2002). The physical maturation and the onset of puberty during adolescence include a rapid increase in growth, the development of primary and secondary sex characteristics, and changes in body composition. Reproductive changes involve the maturation of gonads, growth and changes in the genitals and breasts, and the growth of body hair. These pubertal changes are stimulated by an increase in female sex hormones (e.g. estrogen).

In the cognitive domain, adolescents are building the capacities to think abstractly, consider several dimensions of problem, process information efficiently, and reflect on the self and life experiences (Keating, 1990). According to Piaget's theory of cognitive development, adolescents learn to do formal operations which are characterized by the use of propositional

thinking, combinatorial analysis, and abstract reasoning (Muuss, 2006). Piaget (1969) mentioned that adolescents develop the ability to think logically and think about the consequences of their behaviors.

As adolescents mature physically and cognitively, they begin to search for a firm sense of who they are and how they fit into the social world in which they live. These self-definitional changes and the establishment of autonomy and identity are normative developmental tasks of adolescence. According to James Marcia, who expanded Erikson's identity constructs (identity vs identity confusion) four identity statuses emerge till an adolescent establishes his/her identity: identity diffusion, foreclosure, moratorium, and identity achievement (Muuss, 2006).

Identity diffusion status is when the individual "has no commitment to occupation, religion, or politics, and has not yet developed a consistent set of personal standards for sexual behavior, and by implication, for any of the goals, values, and choices, of the other domains" (p. 62). Foreclosure status is when the person is committed to goals, and values, and an occupation. Individuals in this status may appear as identity achieved individuals; yet, they are different because they have not gone through the personal exploration. The risk in foreclosure for adolescents is that they become "solidified" in their values and attitudes so they do not move easily toward identity achievement (Muuss, 2006). The third status is moratorium. It is defined as "a developmental period during which commitments either have not yet been made or are rather exploratory and temporary" (p. 66) which reflects that the person is still exploring and searching for his/her values and identity. The final status is when identity is achieved after the person has experienced moratorium and has explored identity issues and crises, and as a result, has begun to develop more permanent personal commitments.

Changes in the physical, cognitive and identity domains are accompanied by social transitions. Adolescents spend less time with their families and more time in recreational, academic, and social activities outside the family setting as compared to younger children (Larson, Richards, Moneta, Holmbeck, & Duckett, 1996). School is an important institution with which young people are involved and it is a primary context for their social development. The environment of school may include the factors that can enhance the development of both problems and skills of adolescents, and also risk-taking behaviors, such as sexual activity and drug use (Jones, 2011).

During this stage of development peer relationships become important in adolescents' lives. Peers may provide each other with advice and support (Buhrmester, 1996), and serve as powerful models of behavior (Sussman et al., 1994). Their influence on adolescent development and health behavior is complex and the research results are inconsistent. For example, whereas perceived peer support is positively associated with adolescent smoking (Kristjansson, Sigfusdottir, Allegrante, & Helgason, 2008), in the context of alcohol abstinence it is reported that perceived peer support decreased the likelihood of alcohol use (Groh, Jason, Davis, Olson, & Ferrari, 2007).

The fast-growing exposure to media and use of technology among adolescents is another environmental influence that may affect their development and their health behavior. On average, 8 to 18 year olds use media actively for 6 hours daily, often using more than one type at the same time (Roberts, Foehr, & Rideout, 2005). Research revealed that 75% of college students reported that they were first exposed to sex through media, and 15% had constant thoughts related to that exposure (Cantor, Mares, & Hyde, 2003). In one study, 12 to 14 year olds exposed to sexuality in movies, music and magazines were more than twice as likely than those not

exposed to have sex by age 16 (Brown et al., 2006). Regarding internet access, there is also potential exposure to risk behaviors for adolescents. For example, Rich (2011) mentioned that there are weblogs created by adolescents who have chosen eating disorders such as anorexia nervosa and bulimia as a lifestyle. These adolescents post messages for others who want to follow this eating behavior and be a thin person.

Because of these changes and transitions, adolescence is considered a critical stage of development. It is a time of risk-taking and exploration when behaviors are adopted that may continue into adult behaviors affecting later health (Jessor, 1984). Adolescence is the onset of different diseases for adults and older adults because of the followed health behavior and lifestyle during this period of development.

Past research addressed these physical, cognitive, identity, and social developmental changes as individual factors to understand adolescent health behavior. Applying these developmental factors will help explain the individual characteristics for adolescent girls in this stage of development. They also explain how these girls are struggling with their own developmental issues and how important these concepts at the end in shaping their health decision and health behavior. I believe I can not understand the phenomenon I am interested in without taking into consideration the maturational and biological needs of these adolescent girls.

However, these individual factors ignore other social forces that may influence adolescents' health behaviors; there is emphasis on the "ontogenetic" development over the "sociogenic" factors in development (Klein & White, 2008). Adolescents' health behaviors are shaped by other sociocultural and environmental factors. Family is an important and powerful source of information and socialization for adolescents and has a strong influence on their attitudes, decision-making, and behaviors (Miller, 1998). Chilman (1990), in her article about

promoting healthy adolescent sexuality which can be applied to other adolescent's health behaviors, mentioned: "The person's development as a feminine or masculine human being is intricately interwoven with multigenerational family and social systems—systems which are in continuing interaction with each other" (p. 123).

Applying the family context, and especially parent-adolescent relationships, will help examine the social determinants of health embedded in families. Family-level research will help examine cultural factors that shape parent-adolescent relationships and so influence adolescents' health behaviors. In addition, this type of research will help address other contexts to understand the phenomenon. Family factors, such as mother-daughter relationships are usually multidimensional and are influenced by other ecological factors that need to be addressed in order to understand the influence of families on their adolescents' health behaviors.

Health Behavior Definition

Adolescent health behavior is difficult to define. I can simply define it as the behavior a person follows to protect and promote his health. Yet, I was looking for a broader definition that pays attention to both the individual and the family context. Chilman (1990) gave healthy adolescent sexual behavior a comprehensive definition that I'd like to apply to adolescent health behavior in general. She mentioned: "They accept their own sexual desires as natural but to be acted upon with limited freedom within the constraints of reality considerations, including their own values and goals and those of significant others" (p. 124). Therefore, I define healthy behavior of adolescents as actions regarding certain desires with limited freedom within the constraints of reality considerations, including their own values and goals and those of significant others.

Mother-Adolescent Daughter Relationship, Maternal Practices and Adolescent Health Behavior

The U.S. Department of Health and Human Services (2010) announced that adolescent health, nutrition and weight status, physical activity, substance abuse, and tobacco use are topic areas within the major goals of Healthy People 2020. Healthy People 2020 is the United States' current plan to promote and improve the nation's health in the next ten years. To achieve these goals, Healthy People 2020 emphasizes health equity to address the social determinants of health and promote good health for all Americans.

Data from the Centers for Disease Control and Prevention (CDC) (2004) indicate that adolescent girls in the United States have less healthy eating behaviors than boys; they eat less fruit, less vegetables, and consume less milk. Adolescent girls often diet, have disordered eating behaviors (e.g. bulimia) more than boys, and exercise less than boys (Mackey & La Greca, 2007). Regarding ethnicity, Mackey and La Greca found that Black adolescents follow unhealthier eating behavior 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 maternal relationship. Throughout adolescence the mother-daughter relationship reflects the tension between the tasks of separation and the need to stay connected (Kenemore & Spira, 1996). Gilligan, Rogers and Tblman (1991) refer to this as a fusion of closeness and identity so that adolescent daughter likes keeping a good relationship with her mother while simultaneously establishing her individuality. A mother during this stressful period must try to understand her

daughter's developmental needs and make a shift in her parenting style, so that positive mother-daughter relationship, parental availability, and open communication with the daughter become salient (Pearson, Muller, & Frisco, 2006). Reserachers have documented the important and integral role that mothers play in shaping and influencing attitudes and behaviors of adolescents regarding different health issues, such as eating behavior, substance use and sexuality (Branstetter, Cottrell, & Furman, 2009; Jaccard, Dittus, & Gordon, 1996; Stolley & Fitzgibbon, 1997).

The mother-daughter relationship quality includes positive interactions, support, and relationship warmth. Relationship quality influences the health behaviors of adolescent females. For example, adolescent girls struggling with eating disorders may have been offered less care (e.g. warmth and responsiveness) by their mothers than other adolescents who are not struggling (Mallinckrodt, McCreary, & Robertson, 1995). Motl and his colleagues (2007) found that perceived social support from the family can encourage adolescent girls to participate in physical activity. They mentioned that the “enactment of physical activity often requires the support of others” (p. 10) such as family. Mothers who provide support and guidance to their children will probably help them in abstaining from drugs (Coombs & Landsverk, 1988). In addition, a positive mother-daughter relationship decreases the probability of early sexual debut among adolescent girls (McNeely et al., 2002).

This positive mother-daughter relationship may provide a rich context to encourage enhanced communication between mothers and their daughters (Miller, 2002). The quality of the relationship and communication between adolescent girls and their mothers are important factors to consider when exploring health behavior so that supportive mother-adolescent girl relationships characterized by open communication will decrease the probability of risky health

behaviors among adolescent girls. Additively, when the quality of the mother-daughter relationship is positive, maternal values, such as those relating to responsible behavior, may have a great impact on adolescent girls. Adolescents who feel supported and cared for by their parents tend to be more receptive to their guidance and more accepting of their values (Lefkowitz, 2002). If adolescents are generally satisfied with the relationship with their mothers, they may be more likely to pay attention and accept information from them. In fact, adolescents are more likely to behave in ways that directly oppose their parents if they are unhappy or dissatisfied with the relationship (Jaccard, Dittus, & Gordon, 1996; 2000).

Mother's Availability. A mother can influence her daughter's health behavior by being available and involved in her life. 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). Parents' availability is so important for adolescent girls, because parental availability will help them feel safe, held, less vulnerable to risky behaviors, and more open to prosocial behaviors, such as academic achievement (Crosnoe, Erickson, & Dornbusch, 2002; Straus, 2007).

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, Neill, & DeVoe, 2001). Sharing meals with adolescents is another aspect of availability which helps adolescents avoid engaging in problematic behaviors because a shared mealtime indicates an organized family life (Hofferth & Sandberg, 2001). In addition to that, family meals appear to be an important factor in encouraging healthy dietary intake among adolescents. 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).

Maternal Monitoring. 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, Heron, & Herting, 1997). The mother usually has the role of “food gatekeeper” and has a considerable impact on controlling the dietary behavior 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 (Edmunds & Hill, 1999). 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, Furman, & Cottrell, 2009) and low parental control projected adolescent smoking initiation (Blokland, Hale III, Meeus, & Engels, 2007). In sexual health, African American and Latino adolescent female sexual behavior is associated negatively with maternal monitoring so that maternal monitoring predicts less sexual activity of the daughters than those who are not monitored by their mothers (Miller, Forehand, & Kotchick, 1999). In addition, mothers may monitor and limit their daughters’ time spent watching television or playing computer which may help the girls and encourage them to be physically active and enjoy different sports.

Health Communication. Health communication between parents and their children has been found to be an important contributing factor related to health behaviors. Communication can be direct through specific and verbal comments about behavior, and or indirect through modeling behavior (Baker, Whisman, & Brownell, 2000). In direct communications, mothers should take into consideration what they are saying to their daughters and how they are saying it.

They should pay attention to the content and process of the communication with their daughters (Miller, 1998).

Mother-daughter direct 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. Communication about facts and the negative consequences of irresponsible sexual behavior may provide the girl with accurate health knowledge and enhance reductions in unhealthy or risky sexual behaviors (Pick & Palos, 1995). Similarly, 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, exercise, and sex (Reis, 1996). Values can be transmitted either through discussions about certain behaviors occurring among other members of the family or friends, or the discussion of societal problems (Dilorio, Hodkenberiy-Eaton, Maibach, Rivero, & Miller, 1996; Nolin & Paterson, 1992). Parents can develop in their adolescents a set of motivations for responsible behavior by including consideration of the social, familial, and moral negative consequences of irresponsible behavior (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, & Callads, 2008).

How communication occurs between the mother and her daughter is another important factor that may influence the girl's health behavior. 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 (Miller, 1988). 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 (Block, Block, & Keyes, 1988). 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 behaviors, and thus avoid risky behaviors (Lefkowitz, 2000).

Behavior Modeling. Another maternal factor that may relate positively to health behavior of adolescent girls is maternal modeling of the health behavior. Parental modeling 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). In the eating domain, there is evidence that mothers can influence their children’s eating behavior and dietary intake by acting as role models (Rossow & Rise, 1994). Hispanic and African American mothers who act as role models for their daughters in their dietary intake by eating fruits, vegetables, and low dietary fat were able to enhance healthy eating habits for their girls (Fitzgibbon, Stolley, Avellone, Sugerman, & Chaves, 1996; Stolley & Fitzgibbon, 1997). Adolescent girls are also influenced by their mother’s drug use behavior, so that girls who have mothers who smoke will most probably smoke cigarettes and even use marijuana themselves (Brook, Rubenstone, Zhang, & Brook, 2012).

Some parents may be selective of which behaviors they choose for modeling (Tibbs et al., 2001). For example, mothers may prepare healthy meals at home having all the family members around the table, but when eating outside or having a snack these mothers may choose unhealthy (e.g. high-fat and high-salt) food. This may affect the perception of the adolescent daughter who sees her mother as a role model for her eating behavior. The daughter may be confused and

believe that her mother is unclear about her health values. Tibbs and his colleagues explained that part of this selectivity can be related to the cultural values of the mother (2001).

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

Maternal Values of Health, Adolescent's Perception and Health Behavior

Values are the "standards of right and wrong" or "the general goals of an individual" (Padilla-Walker, 2007, p. 675, 677). 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 modeling, mothers share their health values with their daughters which may contribute to their daughter's health behaviors.

Research reveals that mothers who show conservative attitudes toward sexual behavior to daughters will probably have daughters who reject permissive sexual values when they are in committed romantic relationships (Bynum, 2007). In the domain of eating behavior, where parents set the norms, the less permission to eat unhealthy food such as candy instead of eating family meals, the more healthy food choices the children will make (Bourdeaudhuij & Oost, 1998).

Within the mother-daughter relationship, researchers have generally ignored the perception of daughters and have focused instead on listening to mothers about how they value this relationship. Accepting or rejecting maternal values by adolescent girls as their personal values depends on how they perceive these values (Grusec & Goodnow, 1994). So that when adolescent girls have accurate perceptions of their mother's values, then probably they will accept these values as their personal values. On the other hand, if they have an inaccurate perception of these values, then they are more likely to reject the parents' values as their personal values.

In addition, previous research has shown that accurate perception and acceptance of maternal values are positively related to adolescents' personal values and to their prosocial behaviors (Padilla-Walker, 2007). As a result, if an adolescent girl has an accurate perception of her mother's health values, then she is most likely to accept these values as her own health values, and as a consequence she may follow healthy behavior. Weiss and his colleagues (1996) reported that there is a positive relationship between adolescent's values on health and the overall participation in different health behaviors. The converse is also true. Padilla-Walker (2007) found that accurate perception and acceptance of maternal values were negatively related to adolescents' negative (risky) behaviors such as substance use. So, when the daughter has accurate perception and acceptance of her mother's health values, then she will probably avoid unhealthy behaviors such as unhealthy eating behavior, low physical activity, or smoking and will instead follow a healthy lifestyle.

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 &

Fitzgibbons, 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 if their adolescent daughters have accurate perception and acceptance of these unhealthy values as their own personal values, then most probably these girls will follow unhealthy behaviors.

A Gap in the Literature

Immigrant Muslim mothers is 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. Approximately 4 million adolescents in the United States have Arab Muslim immigrant parents (Arab American Institute, 2007). Research about the health status of Arabs (the majority whom are Muslims from the Middle East) residing in the United States, Detroit area, indicates that cardiovascular disease is a widespread health risk among them because of the prevalence of cigarette smoking, high-cholesterol diets, obesity, and sedentary lifestyles (Wayne County Health Department, 1994). The prevalence of tobacco use among Arab Americans in the Detroit area was reported at 40% for men and 38.2% for women (Rice & Kulwicki, 1992). In order to understand how immigrant Muslim mothers' values can influence the health behavior of their adolescent daughters in the United States, we need to explore the factors that shape these values and maternal practices: religion, culture of origin, and acculturation.

Religion (Islam), Muslim Mother's Values and Maternal Practices

Mothers vary in their values regarding parenting their children (LaVine, 1980). Muslim mothers' values regarding parenting are influenced by religion (Maiter & George, 2003) since religion is considered part of the identity of the individual which explains what is happening in

one's life and behaviors (Hjarpe, 1997). Religion includes religious beliefs – “meanings and perspectives that are faith-based” and practices which are “the expressions of faith” (Marks, 2006, p. 604). In order to understand the influence of Islam as a religion on a mother's values regarding health and on motherhood practices in the United States, I decided first to return to the religious writings of Islam, the Qur'an (the Muslims holy book), and Hadith (the teachings of the Prophet Mohammed).

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

Hadith mentioned:

“Each of you is a guardian and is responsible for his ward. The ruler is a guardian and the man is a guardian of the members of his household, and the woman is a guardian and is responsible for her husband's house and his offspring, and so each of you is a guardian and is responsible for his ward” (Al-Bukhari, 1997).

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 behavior and moralities. She should teach her children about their religion through practices such as reading Qur'an, recitation of the Qur'an, and performing religious practices based on the five pillars of Islam: declaration of the faith, praying five times a day, almsgiving, fasting the month of Ramadan, and making a pilgrimage to Makkah. Followed are examples from Hadith;

“Narrated Ibn 'Umar: What does a parent leave as an inheritance for his child (that is) better than good morals?” (Ibn 'Asakir, 1954).

“From the Hadith of 'Amr Ibn Shu'aib on the authority of his father, on the authority of his grandfather, he said: The Messenger of Allah said: Order your children to pray at seven” (Abu Dawud, 2000).

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 behaviors 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 behaviors:

“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).

Honoring Mothers in Islam. All these efforts of the mother put her in a high position in the family and in society, and open the doors of paradise for her as mentioned by Prophet Mohammad: "Paradise is at the foot of the mother" (Al-Bukhari, 1997). The Qur'an highlights the importance of honoring the mother because of the pain she may face during pregnancy, birth and nursing, "And we have commanded that it is essential for man to be kind to his parents: In pain did his mother bear him, and in pain she give him birth. The carrying of the child to get him to eat food away from the mothers milk is a period of thirty months" (Qur'an, 46:15).

Hadith showed many examples about how Islam honors mothers,

"Narrated Abu Hurairah: A man came to Prophet Muhammad and asked, 'O Messenger of Allah! Who is more entitled to be treated with the best companionship by me?' The Prophet said, 'Your mother.' The man said, 'Then who?' The Prophet said, 'Your mother.' The man further said, 'Then who?' The Prophet said, 'Your mother.' The man said again, 'Then who?' The Prophet said, 'Then your father' " (Muslim, 2007).

Because of this honor, Muslim mothers believe that motherhood is a big responsibility and a difficult task and have high expectations and goals regarding parenting their children.

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. Consequently, the second factor which influences immigrant Muslim mother's values regarding parenting in the United States is culture 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" (Islam & Johnson, 2003, p. 321). They are issued to deal with behaviors 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. So a Muslim mother from South Asia (e.g. Pakistan) may follow a school of fiqh and fatwas that is different from a Muslim mother from West Asia (e.g. Palestine) and so they will differ in their practices of Islam and in their values regarding parenting and teaching their

children about Islam. This emphasizes the fact that Islam is flexible and can be applied anytime and everywhere.

For example, different Muslim countries have different fatwas regarding smoking, since there is no specific rule (such as those for drinking alcohol and premarital sex) about smoking mentioned in the Qur'an or Hadith. 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 Islam & 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 behavior 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 behavior. Yet, we may also find other Muslim mothers who smoke and so influence or even encourage their daughters to smoke.

One's culture of origin can be defined as "a set of characteristics, behaviors, rituals, and beliefs that are used to describe a group of people who: (a) live within (or originated from) a specific country or geographical region, (b) share a religious affiliation, (c) claim common ancestry and heritage, or (d) are grouped together for other reasons" (Myers-Walls, Myers-Bowman, & Posada, 2006, p. 148). One's culture is not only religion, it also is a combination of factors that can shape individuals' values and behaviors. Individuals usually make commitments and adhere to values that are accepted by their culture and society as a whole, and a mother's

values in parenting her children are greatly influenced by what is approved by her culture (Myers-Walls, Myers-Bowman, & Posada, 2006). Despite sharing some parenting goals and expectations, mothers from different cultures have different values in parenting their children (LeVine, 1980).

An example of this cultural diversity within the Muslim community is teaching children how to swim. Teaching children, girls as well as boys, to swim is encouraged by Islam in order to make them strong and physically active. But Muslim mothers from different cultures may not have the same values regarding swimming. A Muslim mother who is from a culture where it is uncommon for girls and women to swim may undervalue the advantage of practicing this activity and see that there is no need to share this health value with her daughter. In these cultures women believe that dressing in swimming suits in front of other women and girls is prohibited by religion and culture. In other Muslim countries where it is common for girls to have swimming classes and practice this sport, we may see mothers who value this activity and would like sharing this with their daughters to encourage them to practice swimming.

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. All of these mothers may feel that they are practicing the right way to teach their religious and cultural values to their children.

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. In order to have a clear understanding of immigrant Muslim mothers' parenting practices one should be aware of the three contexts in which parenting practices are embedded: religion, culture of origin, and the dominant new culture.

Acculturation, Values, and Muslim Maternal Practices in the United States

Mothers use different parenting practices or behaviors that are defined as “a series of actions and interactions on the part of parents to promote the development of children” (Brooks, 2004, p. 5). Immigrant mothers in the United States are considered different from the host culture in their parenting practices because of the challenges they face raising their children in a culture different from the culture they grew up in. These mothers struggle to find a balance between the two cultures, primarily trying to be involved in the new while staying connected with their culture of origin (Tummala-Narra, 2004).

Acculturation can be defined as the process that starts with adopting the traditional and cultural values of country of origin, then trying to have a balance between the two cultures (biculturalism), and finally adapting to the traditions, values and behaviors of the new host culture (Day & Cohen, 2000). Immigrant Muslim families in Great Britain are different in their parenting practices regarding the extent of acculturation in the new host country (Basit, 1997). Some immigrant families may emphasize following their culture of origin values, and they strongly encourage their children to speak their native language and practice their religious and cultural traditions. Others may seek assimilation in the host society, placing less emphasis on

their culture of origin, discouraging their children from speaking their native language or practicing cultural traditions.

Islam is the fastest growing religion in the United States (Haddad, 1997) with 7 million Muslims from different ethnic origins (Council on American–Islamic Relations, 2003). The majority of these Muslims are immigrants from other countries (Smith, 2003). Immigrant Muslim mothers in the United States are facing many challenges in parenting their adolescents: (1) They are far from the culture of origin that would typically provide the support needed to pass the religious and cultural values to their daughters, (2) they are in a culture which is not only non Islamic but contains values that can be contradictive of the values taught in Islam and (3) they are in a culture that has stereotypes about Islam and Muslims which often includes the fallacy that all Muslims are terrorists, especially after the events of September, 11, 2001.

Loss of Social Support. Immigrant Muslim mothers teach their adolescents about Islam and about their culture of origin in the new culture (Al-Mateen & Afzal, 2004). They do this while lacking the needed social support from their extended family members, relatives and neighbors back home which make it an emotionally and mentally draining task. South Asian Muslim mothers in Canada described that part of their parenting goals and practices are to transmit to their children their cultural values which include “respect for elders, modesty, humility, hard work, persistence, perseverance, and having a disciplined life” (Maiter & George, 2003, p. 420). These mothers reported that the best way to internalize these values in their children is to follow and practice Islam.

In order to promote an Islamic lifestyle for their children and compensate for the loss of social support, Muslim mothers in the United States may pray frequently with their children, take them to religious education classes and celebrations in the mosques, and participate in activities

and programs of their countries of origin within their communities (Ross-Sheriff, Tirmazi, & Walsh, 2007). In addition, these mothers may choose Islamic schools for their children and encourage them to have immigrant Muslim friends instead of Americans. Some Muslim mothers believe that this will help their adolescents have the sense of belonging to a group, develop religious and cultural identity and so enhance healthy development for these children.

However, this is not the case for all Muslim mothers because there are differences in the adjustments they make regarding their parenting values in the new culture. When it comes to practicing religion in the United States, Maloof and Ross-Sheriff (2003) found that American Muslims vary from liberal to conservative. Mothers in the new culture may recognize that they need to make changes in the way they practice Islam because their children would know about their religion and know how to practice it in the new culture. Some immigrant Muslim mothers may feel the need to adhere more firmly to religious customs in the new culture than they did in their country of origin. On the other hand, others may feel that they need to be flexible in teaching their children about religion or they may lose their children if they pressure practicing Islam on them (Maiter & George, 2003).

Value Conflicts for Mothers. A new culture imposes a new social context on immigrant Muslim mothers' parenting practices with values and traditions that are in contrast with the ones accepted and approved by Islam and their culture of origin (Ross-Sheriff & Husain, 2004). For example, immigrant Muslim mothers find that American culture values individuality and encourages autonomy and independence as part of identity formation for adolescents while Islam values and respects group values and encourages adolescents to take into consideration the parents' desires and opinions whenever they need to make decisions regarding different issues in their lives.

Inman, Ladany, Costantine, and Morano (2001) described the “cultural value conflict” as an experience of cognitive conflicts that results from the competition between the values that are adopted from the culture of origin and those that are forced by the new culture. Immigrant Muslim woman will have a traditional identity attached to religion (Qur’an and the Hadith) and country of origin, and on the other hand the modern identity from the new culture (Roald, 2001). As a result, immigrant Muslim mothers may face a challenge and a need to define their values regarding parenting, whether Islamic, American or a mixture according to their priorities and to their children’s needs.

Within this 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 contradictive of Islamic values. Naidoo and Davis (1988) found that South Asian Muslim mothers accept American values that are related to issues of education and work, but not those related to marriage, religion, and gender roles. 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 (education and activities), and keep healthy communication with them (Ross-Sheriff, Tirmazi, & Walsh, 2007).

Muslim mothers recognize that they are part of this new society and that their daughters cannot live isolated from the American culture. Some mothers are flexible about their children’s school and selection of friends because they believe that this is necessary for raising healthy children in the host culture. Although mothers prefer to send their children to Islamic schools and have their children have Muslim friends to emphasize their Islamic and cultural values, some

mothers let their children enter American schools and have American friends but with monitoring of their activities and behaviors. They do so because they do not want their children to feel isolated, and they want them to be active members in the new culture.

One of the basic goals of immigrant Muslim mothers in parenting is their children's academic achievement. They want their children to be successful in school, get a high degree in education, and have a job with a good income. If these mothers choose American schools for their children, they may struggle with choosing the classes (e.g. sex education, music classes) their children can attend. Some mothers may accept their children attending sex education classes at school because they believe that a Muslim person should not be shy when seeking knowledge. Others may think that it is a personal and sensitive issue that parents can discuss with their children at home (Maiter & George, 2003).

September, 11, 2001 and Maternal Practices. Since the tragedy of September, 11, 2001, Muslim families in the United States have had to deal with stereotyping, prejudice and discrimination (Bakalian & Bozorgmehr, 2009). After these attacks some Americans started thinking that all Muslims were terrorists and several discrimination and harassment events against Muslims were recorded. Muslim mothers became worried about their children and how to raise them in a culture that is, they feel, "very anti- Muslim" (Ross-Sheriff, Tirmazi, & Walsh 2007, p. 207). South Asian Muslim mothers in this study mentioned that they sometimes hide that they are Muslims and some even avoid wearing their traditional outfits. They feel that they do not have the freedom to express their faith or practice their cultural traditions.

As a result, this event influences Muslim mothers' parenting values and practices. Some mothers limit their visits to the mosques with their daughters and prefer to practice religion at home because they are afraid of being harassed. Muslim mothers try to be closer to their

daughters more than before, talk to them, and listen to their concerns and questions. Others place restrictions on their girls' behaviors; for example, some mothers prevent their daughters from going to shop unless they go in groups or with their brothers. And others go as far as preventing their girls from wearing hijab (the traditional head scarf worn by Muslim women) because they would be a "target of harassment and even severe violent action" (Ross-Sheriff, Tirmazi, Walsh 2007, p. 208).

Acculturation and Adolescent' Health Behavior

Currently, there is no research exploring the influence of acculturation on immigrant Muslim mothers' health values and behaviors. There is, however, limited research about immigrant mothers from other cultures. Immigrant Latino mothers in the United States reported the negative impact of acculturation on their diet, eating behavior, and physical activity (Sussner, Lindsay, Greaney, & Peterson, 2008). These mothers mentioned that they used to have more healthy food available in their country of origin, namely their food was more natural had no chemicals added, more fruits and vegetables, and smaller portion size when compared to the food available for them in the United States. They also reported lower physical activity and more sedentary behavior caused, according to their opinion, by the weather, less walking and more reliance on transportation, and more television watching in the new culture than in their country of origin. 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 also influences mothers' parenting behaviors 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, Lindsay, Greaney, & Peterson, 2008). These mothers also may stop following some behaviors 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.

Results regarding the influence of acculturation on the health behavior of adolescents have been inconsistent. This inconsistency can be related to considering acculturation as a single factor and to the method used to measure acculturation. Previous research focused on measuring the influence of being acculturated or less acculturated and being U.S.-born and foreign-born on the health behavior of adolescents. For example, a high level of acculturation among Latino adolescent girls was found to be positively associated with binge drinking (Lovato et al., 1994). On the other hand, foreign-born Latino adolescents were less likely to use alcohol and have sex at an early age than were U.S.-born adolescents (Marin & Flores, 1994).

Acculturation level was measured by the proficiency in speaking the foreign language and length of residence in the United States. For example, Guilamo-Ramos, Jaccard, Pena, and Goldberg (2005) found that recent Latino immigrant adolescents with low levels of exposure to the new culture and with English-speaking at home were less likely to be sexually active than others who spoke Spanish or had lived longer in the United States. In the eating behavior domain, Neumark-Sztainer and his colleagues (2003) found that Asian American adolescents from recent immigrant families who had the highest frequency of family meals when compared

to White, African Americans, Hispanics, and Native Americans were more likely to have healthier dietary intake than other adolescents.

Recent research indicates that the influence of acculturation on adolescents' health behaviors is a multidimensional process shaped by different factors that need to be addressed in order to understand the impact acculturation has on health (Guilamo-Ramos et al., 2009). Studying the family context with focus on the cultural values of the mother to understand the influence of acculturation on adolescent's health behavior is a crucial factor that has been under-examined in previous research. This study will pay more attention to the mother's values and the factors shape these values in the new culture.

Theoretical Perspectives

Two theories helped me in organizing the literature review and framing the research questions: Symbolic Interaction Theory and Bronfenbrenner's Ecological Approach. These theories also informed the methods and the analysis plan I followed in this qualitative study.

Symbolic Interaction Theory. Symbolic interaction theory (SI) is a conceptual framework consists of a set of concepts and ideas. The sets of concepts are: identities, roles, interactions, and contexts. SI emphasizes that families are social groups and that individuals develop both a concept of self and their identities through social interactions (LaRossa & Reitzes, 1993). The basic assumption of symbolic interactionism is that the explanation of human behavior is impossible without knowing the meaning such behavior holds for the actor. In addition, SI states that effective relationships in families are dependent on nurturing a culture of shared meanings (Klein & White, 2008).

The role concept is one of the most important concepts of SI. It is defined as "the normative expectations attached to a specific position in a social structure" (Klein & White,

2008, p. 104). One dimension of roles is the expectations that both the actor and others have about the performance of the role. The clarity of the role expectations is another important dimension. Without clear expectations shared by both the actor and the others, it is impossible for the actor to perform the role or for others to know how their behaviors coherent with that of the actor. Klein and White (2008) pointed out to how expectations should be shared or consensual and how the clarity of these expectations or rules facilitates enactment or performance of the behavior. Therefore, vagueness or conflict in perceived expectations would result in an increase of role strain that happens when the actor does not have the sufficient resources to perform the role (Klein & White, 2008).

Applying the basic assumptions from symbolic interaction theory and the role concept may help explain how the mother-daughter relationship and Muslim mothering can influence and shape the daughter's health behavior. An important dimension of the role concept is the expectations that both the actor and others have about the performance of the role. Without clear expectations and perceived consensus shared by both the mother and her daughter, it is impossible for the mother to perform the role or for the daughter to know how her behavior agrees with that of the mother.

When the mother is clear about her values and expectations regarding different health behaviors, and she is sharing and communicating this clearly to her daughter, then probably the mother is performing her role successfully and in a high quality and so she has a positive relationship with her daughter. As a result her daughter, probably, will be satisfied with this relationship and she will have accurate perception of these values and expectations which may provide her with the resources needed to make commitments regarding different health behaviors.

On the other hand, vagueness or conflict in perceived expectations would result in an increase of role strain because the individual does not have the sufficient resources to perform the role. Immigrant Muslim mothers' values regarding parenting their adolescent girls are different from the values and expectations of American mothers and American culture. A mother may be torn between her religious and cultural values and the new culture values. If the mother is not clear about her expectations and health values and she is not communicating clearly with her daughter about these values, then probably she is not performing her role as a mother effectively and she is not having a healthy, positive relationship with her daughter. As a result, the daughter may perceive this relationship negatively, and may have an inaccurate perception of her mother's values, and thus may lack the resources that will help her in making commitments regarding different health behaviors.

Symbolic interaction theory helps explain the interaction between a mother and her adolescent daughter and so explain how mother-daughter relationships can be positive and supportive. It puts emphasis on the family context and how the health behavior of the adolescent will be affected, influenced and shaped by the expectations, the rules, and the values that are clearly communicated between the mother and her daughter. There is no predetermined single, generalized formula or script for all adolescents. Each adolescent is unique and each mother-daughter dyad and interaction is different.

On the other hand, SI does not emphasize individual-level factors and personal characteristics of these adolescents within the mother-daughter dyad and the family-level factors. SI emphasizes that families are social groups and that individuals develop both a concept of self and their identities only through social interactions. Ignoring the individual abilities and self-learned experiences is a limitation in Symbolic interaction theory.

Bronfenbrenner's Ecological Approach. In order to understand the influence of mother-daughter relationships and maternal practices on the health behavior of adolescents, we should be aware of the contexts, and interrelationships between contexts in which this relationship and these interactions occur. Bronfenbrenner's ecological approach to the study of human development has focused on the interaction between the developing child and the immediate environment in which he or she lives, and the influence of the broader context in which this interaction takes place (Bronfenbrenner, 2005). These contexts, according to Bronfenbrenner, are microsystems, mesosystems, exosystems, and macrosystem.

Applying these principles to understand the ecologies and contexts in which the mother-daughter relationship is embedded will enable us to understand the complexity of this relationship and how it can influence the adolescent daughter's health behavior. Within the Muslim community, a microsystem may represent the family, the mosque, and the school (Islamic or Public school); a mesosystem may represent the relationships that exist between these different microsystems; an exosystem may represent the impact of the immigrant Muslim mothers' religious and cultural values; and the macrosystem may represent the influence of the dominant new culture.

The microsystem explains the health behavior of the American Muslim adolescent daughter by addressing her relationship with her mother as the context. So that positive and healthy relationships between the mother and her daughter may enhance healthy behaviors for the daughter. In addition, this system may focus on the influence of other environments like school and other relationships of the adolescent daughter with friends and peers. Previous research focused on this context ignoring other ecologies that may shape and influence the mother-daughter relationships and thus the health behavior of adolescent daughters. The

Mesosystem will focus on the relationships between the microsystems and their influence together on the health behaviors of the adolescent daughter; relationships with mother, friends and peers, and the school environment. This system may examine the extent to which the child's Islamic values, beliefs and practices are supported by other settings with which the child interacts (Rashid, 1988).

Applying the exosystem and macrosystem will help explain the other contexts influencing the mother-daughter relationships that I focus on for my study. The exosystem focuses on the impact of external settings that have no direct effect on the daughter. In this study examining the mothers' religious and cultural values; values influenced by Islam and culture of origin, will add another context to better understand how these values shape the mother's practices and her relationship with her daughter and thus the daughter's health behavior.

Finally, the macrosystem explains another context influencing this relationship; acculturation and the influence of the new culture. This context will help examine the struggle of immigrant Muslim mothers in the United States, the value conflict and the adjustments they made in the new culture that will give a better understanding of the factors that shape the mother-daughter relationships and thus the health behavior of adolescent daughters.

Chapter 3 - Methods

This qualitative study examined how American Muslim adolescent girls' health behavior (eating behavior, drug use, and physical activity) can be influenced by her mother. To have a better understanding of the mother-daughter relationship, I studied how the mother's health values shape this relationship. I further examined three contextual factors that shape immigrant Muslim mother's health values: religion, culture of origin and acculturation. It is important to address these contexts to understand the mother-daughter relationships and how they influence the daughters' health behavior within a Muslim community.

Family-Level Research and Qualitative Methodology Rationale

When examining previous research studies conducted on factors affecting adolescent health behaviors (sexuality, obesity or eating disorders, drug use and abuse, and physical activity), the majority are individual-level research studies using quantitative, cross-sectional methods creating a snap-shot which makes it hard to come up with causal inferences, and the majority of the participants are White American males. The clear gaps in this literature include: reliance solely on adolescent self-reports for understanding and explaining the health behaviors, lack of culturally responsive research and ignoring the contexts in which different adolescent health behaviors occur.

Adolescents' self-reported behaviors may signal a need for cautious interpretation because the data could be "spuriously inflated" by common method variance. Adolescents may give socially desirable responses which will limit the accuracy of these measures (Jaccard, Dittus, & Gordon, 1996). When data are obtained from both members of the mother-daughter dyad, agreement can be assessed between the two responses which can reduce the biases

resulting from the use of self-report data from only one family member and permit the examination of maternal values and their effect on the adolescent daughter's health behavior.

Using a sample with a majority of White American adolescents ignores the diversity of minorities in American society. Results obtained from such research can not be generalized to adolescents from other cultures. Each culture has its own values and traditions which play a big role in shaping individuals' behaviors. In order to understand this diversity, it would be better to address the family context and try to understand different familial factors influencing the behavior. Applying the family context will help me conduct culturally sensitive research and understand the values, beliefs and attitudes of the family and how these family factors may influence adolescent health behavior (Kao, Guthrie, & Loveland-Cherry, 2007; Park & Grindel, 2007).

Previous research suggested that adolescent health behavior and the formation and maintenance of a health-related lifestyle is largely up to the individual and so researchers have often ignored the context in which this behavior occurred. This isolates the adolescent from her family, the society, and the environment she is living in, and so ignores the social forces and environmental factors that may affect her behavior. Addressing context is important to help determine appropriate behaviors in other situations and to help implement appropriate interventions and successful programs. Family-level data will help us explain some of these contextual factors and their influence on the behavior.

Studies including only males cannot be generalized to explain the health behavior of females. Gender-specific research is needed to have a clear understanding of the factors influencing health behavior for both sexes. For example, when it comes to sexuality and sexual behavior, Udry (1989) mentioned that the sexual behavior of boys tend to be clearly linked to

biological factors (endocrine/hormones); yet, for girls it is influenced by both biological and social factors. So, to understand the sexual or any other health behavior for girls, it will be better to conduct the research with females so that we can understand the social factors influencing the adolescent girl's health behavior.

The goal of this study is to understand how adolescent girls' health behaviors can be shaped and influenced by sociocultural factors especially the mother-daughter relationship and the influences of living in a Muslim community in the U.S. from an ecological perspective. Therefore, data were collected from both immigrant Muslim mothers and their American Muslim adolescent daughters (at the microsystem level). The immigrant Muslim mother's values (religious and cultural) that shape these relationships and interactions also were examined (the ecosystem level). The final context examined in this study, at the macrosystem level, is the influence of the new dominant culture; the American culture on the mothers' values, maternal practices and thus the adolescent daughter's health behavior. In order to address these contexts, qualitative inquiry is the methodology of choice in this study. "Qualitative methods permit inquiry into selected issues in great depth with attention to detail, context, and nuance" (Patton, 2002, p. 129).

In the literature focusing on the mother-daughter relationship and maternal practices, the perception of the daughters of the relationship and the interactions are underexamined. In this study, I explored how adolescent girls and their mothers feel, perceive, and experience their relationship with each other. Qualitative research within families can expand the understanding of the specific messages (e.g. values) given by parents, how they are perceived by adolescents and the messages adolescents send to parents (Patton, 2002; White & Klein, 2008).

The personal voice and the human aspect in this study can be captured only by qualitative inquiry. Having the quotes and the words of the mothers and their daughters from the interviews will give the study trustworthiness and authenticity, and carry the readers to the real world of those girls and enable them make their own conclusions.

Phenomenological Approach

Phenomenology emphasizes capturing and describing how people 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). In this approach researchers must undertake in-depth interviews with people who have directly experienced the phenomenon of interest – so they have lived the experience.

Applying this approach to the current study provided a deep understanding of how mothers and their daughters perceived the influence of their relationships on the adolescent daughters’ health behavior. This approach helped examine how both perceived their relationships and interactions. By interviewing and listening to both of them I was able to gain insight about the daughter’s perception of her relationship with her mother, which was underrepresented in previous research.

Every mother-daughter relationship is unique and different. In phenomenology, differences are considered expressions of multiple realities (Patton, 2002). Examining the mother-daughter relationship within a Muslim community helped explain how this relationship and these maternal practices could vary from one mother to another because of the different meanings (e.g. health values) each woman assigned to them.

This approach provided good guidance for me when creating the research questions so that I focused on the phenomenon I was studying. In addition, the ways of gathering data were

also affected by this approach since I interviewed only those who had experienced or were experiencing the phenomenon; immigrant Muslim mothers and their American Muslim adolescent daughters in the United States.

Research Questions

After reviewing the literature focusing on the influence of mother-daughter relationship and maternal practices on the health behavior of adolescent daughters, I identified the following gaps: 1) There is a lack of research about Muslim mothers' relationships with their adolescent daughters and their parenting practices in the United States; 2) We do not know the daughters' perceptions of these relationships and practices, 3) There is little information about the influence of the mother-daughter relationship on the health behavior of adolescent daughters; 4) There is a lack of research about the influence of religious beliefs and practices on mothering; 5) We lack research examining the influence of the two cultures – the culture of origin and the new culture – on the maternal practices of immigrant Muslim mothers in the United States.

As a result, the overarching research question is: How do the mother-daughter relationship and mothering practices of Immigrant Muslim mothers influence the health behavior of their American Muslim adolescent daughters in the United States? Specific research questions include:

1. How does religion (Islam) influence and shape immigrant Muslim mothers' health values?
2. How does culture of origin influence and shape immigrant Muslim mothers' health values?
3. How does acculturation in the U.S. influence and shape immigrant Muslim mothers' health values?
4. What is the general nature/quality of immigrant Muslim mother-daughter relationships?

5. What are immigrant Muslim mothers' health-related mothering practices?
6. How do the daughters' perceptions of their mothers' health values (shaped by the 3 factors) influence the daughters' health behaviors?

Participants

Participants are immigrant Muslim mothers and their adolescent daughters (N=22). The mothers aged from 34-50. One mother had a masters degree from the United States, five mothers had bachelors degrees (one had two undergraduate degrees with one degree from the United States), three mothers earned a two-year diploma from their countries of origin, one finished three years in law school in her country of origin, and two of them studied till ninth grade in their countries of origin. Three mothers had full-time jobs, one mother had a part-time job, and the others did not have jobs. The length of residency in the United States ranged from 15-28 years. (See Table 1)

The daughters' ages ranged from 14-18. Two girls were 18 years old, four were 17 years, two were 16, and three daughters were 14. Five of the daughters had jobs and one of them had two jobs. Another girl was looking for a job. These participants were recruited from three cities in the Midwest of the United States from May to August, 2012. (See Table 2)

Table 1

Demographics for Immigrant Muslim Mothers

Participant #	Age	Education	Job	Social Class	Residency in the US	Language used	Country of origin	Hijab
101	41	9th grade	Part time	Below Middle	17 years	Arabic	Jordan	Yes
102	50	Three years in college	No	Middle class	27 years	Arabic & English	Syria	Yes
103	42	Bachelor Degree	Full time	Above Middle	15 years	English	Syria	Yes
104	48	Diploma	No	Middle	19 years	Arabic	Palestine	Not all

		Two years		class				the time
105	35	9th grade	No	Middle Class	17 years	Arabic	Syria	Yes
106	43	Diploma Two years	No	Middle Class	19 years	Arabic	Syria	Yes
107	34	Diploma Two years	No	Below Middle	16 years	Arabic	Kuwait	No
108	49	Two Bachelor degrees	Full time	Middle Class	28 years	English	Egypt	Scarf, Not hijab
109	42	Master degree	Full time	Above Middle	20 years	Arabic & English	Lebanon	No
110	40	Diploma Two years	No	Middle Class	19 years	Arabic	Jordan	Not all the time
111	50	Diploma Two years	No	Middle Class	20 years	Arabic	Iraq	No

Table 2

Demographics for American Muslim Adolescent Daughters

Participant #	Age	Education	Job	Hijab
201	17	High School Senior	No	Yes
202	17	Finished High school	Yes	Yes
203	14	7th grade	No	Not all the time
204	17	High School Senior	Yes	Not all the time
205	16	High School Senior	No	No
206	16	11th grade	More than one	Yes
207	14	8th grade	No	No
208	18	Freshman in college	Yes	No
209	18	Freshman in college	Yes	No
210	17	High School Senior	No	Not all the time
211	14	8th grade	No	No

Note 1. All the daughters used English to answer the questions during the interview.

Note 2. 201 took off hijab after few months of the interview.

Sampling and Recruitment of Participants

A criterion sampling strategy was used in the study. The principle of this sampling method is to search and study the cases that meet predetermined criteria that are important for the purpose of the study (Patton, 2002). Criteria for study participation included: Muslim mothers who are: 1) Arab immigrants from the Middle East (Jordan, Palestine, Lebanon, Syria, Egypt, Kuwait, and Iraq), 2) living in the United States for no less than 12 years; 3) have adolescent daughters aged 12-18 years old who were born in the United States and had also been raised in the United States. By following the criterion sampling I was able to select information-rich cases of immigrant Arab Muslim mothers and their American Muslim adolescent daughters. This strategy helped illuminate the research questions and thus examine the phenomenon in depth.

Flyers inviting participation were posted in three Islamic Community Centers. These flyers also were sent by the directors of the centers through the Internet to the e-mail lists they have for their Muslim community members. In addition, the flyers were posted in some Middle

Eastern restaurants, grocery stores, and in a hair salon owned by immigrant Muslim men and women. The recruitment material explained the inclusion criteria, basic information about the study, and contact information for me. Next, snowball sampling was used in which one participating mother or daughter may refer another qualifying mother and daughter whom they know. Patton (2002) explained, “by asking a number of people who else to talk with, the snowball gets bigger and bigger as you accumulate new information-rich cases” (p. 237).

After I had the phone number for the mother I would call her and screen her for the inclusion criteria. If a mother met all the criteria and agreed to participate, the mother would approach her daughter to request her participation. The mothers preferred talking to their daughters about participation before I approached them. This is a common cultural practice in the Muslim community to protect their daughters from strangers. After the daughter agreed to participate in the study, interviews were scheduled for the mother and her daughter.

Procedure

Data Collection

In-depth, face-to-face, semi-structured interviews were conducted with the mothers and their daughters separately because some mothers and daughters may be hesitant to answer the questions in front of the other. Therefore, conducting these interviews separately enabled both members to feel free answering any question, and so enhance the accuracy of the findings. One interview was conducted in the Islamic Center, three interviews were conducted in the public library and seven interviews were conducted in the participants' homes.

Before I began the interview, I used to explain the study and what was expected from the participants. Each participant, mother signed a consent form for her participation and another for

her daughter prior to each interview. Each daughter signed an assent form prior to the beginning of her interview indicating her willingness to participate. I also gave the participants an opportunity to ask any question they might have.

The interview questions were written in English and then translated to Arabic. At the beginning of each interview participants; mothers and daughters, were given the choice to use whatever language they liked when answering the questions. Then during the interview I would match the language the participants used to answer the questions. All the daughters' interviews were conducted in English. Only two mothers answered the questions in English using a few Arabic expressions from time to time. Another two participants used both languages at the same time. The other participants answered the questions in Arabic. In addition to these questions, other follow-up questions were used to elicit more information and investigate deeper into the phenomenon. Being familiar with Middle Eastern Muslim culture, probes, such as gently nodding my head (nonverbal) during the interview, were used to indicate that I was listening and to show respectfulness to what the participant was saying. Probes were used to deepen responses to questions and to increase the richness and depth of responses (Patton, 2002). At the end of each interview, participants were given the opportunity to add any information they felt was important to the study.

There was a set of questions asking about the perceptions of the mother-daughter relationships for the mother and her daughter, including availability, monitoring, communication, and behavior modeling. The second set of questions were about maternal values regarding eating behavior, drug use, and physical activity, factors shaping these values, and how the daughters perceived these values and as a result how all these maternal factors might influence the health behavior of the adolescent daughter. (See Appendix A for the interview schedule.)

Each interview lasted approximately 1 hour for the mother and 45 minutes for her daughter. The interviews were digitally recorded. I took notes to create a clear picture about how these interviews went and the reactions of the interviewees to the questions. Participants were asked about the possibility of conducting additional interviews to clarify any issue raised from these interviews and all of them agreed. Only one participant, a mother, needed follow up. So I called her by phone to ask some questions and clarify some points.

Data Management

Transcription. The interviews were transcribed verbatim using Express Scribe software. I transcribed the interviews myself to be immersed in the data which helped generate emergent insights. In addition the handwritten field notes I took during the interviews were typed and organized. Silverman (2000) suggested that taking field notes is the start of data analysis process.

Transcription is always a representation and interpretation of what the participants are saying. Denaturalized transcribing, which keeps the oral language such as “um,” “uhuh” (Bucholts, 2000), was followed. In a denaturalized approach, the vision is that “within speech are meanings and perceptions that construct our reality” (Oliver et al., 2005, p. 1274). Transcription was a challenge for me since I was also translating from Arabic to English for several of the mothers. But what made it easy on me is that I am a native speaker of Arabic, which was the language used by the research participants.

I listened to what the participants were saying in Arabic by using the Express Scribe program. It allowed me go back over text several times and change the speed and the volume of the sound until it was clear and understandable. First, I did the translation, then I transcribed the interviews. I translated word by word to capture the meaning of the participants, but this did not work all the time because some of them used both languages at the same time. This was

challenging to capture, but I listened to whole sentences and then translated to English and see if this captured the meaning the participants expressed.

Data Preparation. Each transcript was formatted into a Microsoft Word table consisting of four columns as suggested by La Pelle (2004): “Participant Name “Theme Code “Interviewer Question/Participant Response,” and “Sequence #.” A new row was created in the table for each unique speaker. For example, each time the interviewer spoke, a row was created for the question/utterance. A new row was also created for the response/utterance from the participant. All of the interviewer’s quotes were boldfaced. Using these tables helped me in coding the data, merging tables for different participants, and sorting data in different ways (Miles & Huberman, 1994).

Participants were assigned numbers; # 101, # 102, and # 103, etc., to ensure confidentiality. All identification information was removed from the transcripts. Part of the confidentiality agreement with participants was that names and identifying information (e.g., towns, specific places, etc.) would be removed from transcripts. During transcribing anytime the participant said a person's name, I used brackets to identify whom the person was talking about.

Protecting the Data. Interviews and notes should be treated as valuable material and should be protected (Patton, 2002). In order to protect my data, I made three copies of each transcript. The master copy was in a safe place at my home, another one was saved on the computer for cutting and pasting, and the third was used throughout the analysis process.

Analyses

Epoche. In phenomenological research methods the epoche process is “a preparation for deriving new knowledge but also as an experience in itself, a process of setting aside predilections, prejudices, predispositions, and allowing things, events, and people to enter anew

into consciousness, and to look and see them again, as if for the first time.” (Moustakas, 1994, p. 3). In the spirit of Epoche and induction, I explicitly identified my biases, expectations and reactions in order to open my eyes to the others’ reality in front of me.

While conducting the interviews, transcribing, and then during the analysis and interpretation processes I attempted to remain clear and open minded. I was ready to learn from these mothers and their adolescent daughters about their experience in the United States. I was eager to understand the challenges they were facing in the new culture and the adjustments they made while raising daughters who were in a critical stage of development; adolescence. Anything told to me by my mother, anything I still remembered from how my mother raised me, the type of mother-daughter relationship I had, the “typical” mother-daughter relationship according to Islam or the Middle East culture, and all my religious and cultural values were put aside. I was open to any new experience and nothing was determined in advance.

Phenomenological Reduction. Phenomenological reduction includes “describing in textural language just what one sees, not only in terms of the external object but also the internal act of consciousness, the experience as such, the rhythm and relationship between phenomenon and self.” (Moustakas, 1994, p. 8). So there is return to self, which is an essential requirement that can not be ignored in phenomenology and in qualitative research in general. Although I attempted to set all my biases and expectations aside, I described what I saw through my own experience of mother-daughter relationships and the meanings they generated in my awareness.

I was open and followed inductive qualitative analysis which involved discovering the themes in my data. Data analyses began following the first interview and continued throughout the remainder of the data collection process. Developing a coding scheme is the first step of analysis which means analyzing the core content of the interviews to determine what is important

to answer the research questions (Patton, 2002). Several readings of the data from the first interview and referring to the research questions were helpful for me in finding the themes and coding. Moustakas (1994) called this process: *Bracketing* in which “the focus of the research is placed in brackets; everything else is set aside so that the entire research process is rooted solely on the topic”. (p. 15). The frequent interaction with the data created the opportunity for new findings to emerge.

I analyzed the data by using constant comparisons; pieces of data were compared for similarities and differences (Corbin & Strauss, 2008). At the beginning each statement was treated as having equal value. Later, statements not related to the topic and the research questions were deleted, leaving only the *horizons*, “the textural meanings and invariant constituents of the phenomenon.” (p. 15). Horizons that were similar were grouped together into a theme and were given a conceptual label later. Each theme was given a number (e.g. 1.00, 2.00, etc.) and I was able to develop the codebook with a list of the themes that I found in the first interview.

Next, I read the other transcripts and coded all of them using the codebook I made. More themes were added to the codebook as they emerged from subsequent interviews. Constant comparisons were conducted to differentiate one theme from another and to identify dimensions of the themes (Corbin & Strauss, 2008). With each addition of new data, themes were added and modified as needed. Then I came up with subthemes and gave them numbers (e.g. 1.10, 1.20, etc.). Finally I organized the themes and their horizons under them into a coherent textural description of the phenomenon.

Imaginative Variation. While reading through the transcripts again and again I recognized the presence of some relationships among the themes. I started writing memos about these relationships after reading the first interview and continued until the end of the analysis

process. As the research process progressed, the memos became more elaborate and integrated. These memos enabled me to think about the data and how concepts/themes were related to one another. Corbin & Strauss (2008) mentioned that memos were used as a way to record developing ideas about codes, categories, and the theory (or theoretical model).

Next, I was able to make connections among the main concepts. This enabled me to build a theoretical model that helped explain how immigrant Muslim mothers in the Midwest of the United States could influence their adolescent daughters' health behavior. This is what Mostakas (1994) described as "searching for the exemplifications that vividly illustrate the invariant structural themes and facilitate the development of a structural description of the phenomenon. (p. 18).

The Synthesis of Meanings and Essences. In the final step of analysis, I put the major themes with the horizons describing them and the theoretical model together to describe how immigrant Muslim mothers can influence their daughters' health behavior through different maternal practices and under the influence of different ecologies. Mostakas (1994) described this as the "intuitive integration of the fundamental textural and structural descriptions into unified statement of the essences of the experience of the phenomenon as a whole." (p. 18).

Theoretical sampling and theoretical saturation. Theoretical sampling is defined as "sampling on the basis of concepts derived from data" (Corbin & Strauss, 2008, p. 65). In order to employ theoretical sampling, I looked for situations that would contribute to a deeper understanding of the categories, variations within the categories, as well as relationships between concepts. For example, I recruited women from different countries from the Middle East (Palestine, Jordan, Lebanon, Egypt, Syria, Kuwait and Iraq) rather than focusing on only one or two countries. I recruited women who have hijab and others who do not have one. I also

recruited mothers from different educational levels, social classes and lengths of residency in the United States. For the daughter I tried to find different ages between 12-18 years old. In addition, data was gathered till theoretical saturation (i.e., “all categories are well developed in terms of properties, dimensions, and variations” (Corbin & Strauss, 2008, p. 263) was reached and at which additional data did not provide any new insights.

Research Credibility

To enhance the credibility of this research study I worked to have a good match between the purpose of the study, the theoretical perspectives, the unit of analysis, the data collection technique, and finally the analysis plan. Applying phenomenological research methods helped me focus on the purpose of the study and kept me open to any emergent theme during the process which helped me understand the phenomenon in which I am interested.

Triangulation

In order to enhance the credibility of my research, I applied triangulation in different stages of the study. Patton (2000) defined triangulation as “the attempt to get a ‘true’ fix on a situation by combining different ways of looking at it or different findings” (p. 177). The first type of triangulation was having multiple data sources. I interviewed both mothers and their daughters, as well as I took notes during the interviews. Different kinds of data in a case study can be brought together to illuminate various aspects of the phenomenon.

I also used investigator triangulation -- using more than one person to do the data analysis. For this study, two researchers (my major advisor and I) worked independently to analyze the data to help in the verification process. We read the transcripts and identified the

common themes separately. Because we were in different states, we skyped and made phone calls several times to compare notes on the themes and come to agreement.

My major adviser is considered an outsider in this research since she is not Muslim and she is not an immigrant woman from the Middle East. She is a White American mother and as a result her analysis was from a different perspective from mine. She is not an Arabic speaker; therefore, she relied on my translation. However, we discussed the meanings of the women's expressions as we analyzed the transcripts. This triangulation reduced systematic bias and distortion during data analysis (Patton, 2002). It also increased the credibility and quality of the findings by countering the concern of having a single analyst who is an insider.

The third type is theory triangulation. As previously mentioned, symbolic interaction theory (SI) and Bronfenbrenner's Ecological Approach (BEA) were used to organize the literature review and frame the research questions. These two theories influenced every step in this research study starting from data collection till data analyses and even findings' interpretation. Although they are different, they also complement each other. SI provided an explanation for the perception of the mother-daughter relationships for mothers and their daughters and Bronfenbrenner's Ecological Approach will explain the different contexts and ecologies in which this relationship is embedded.

Finally, to enhance the credibility of the analysis process, once themes and concepts were established I examined if there were any deviate (negative) cases or data that did not fit the categories. This adds credibility by showing the "authentic search" for what makes most sense rather than forcing all the data toward a single finding (Patton, 2002).

Credibility of the Researcher

In qualitative research the researcher is the measurement tool. This brings both strengths and weaknesses to any study. This section will briefly describe my life experiences and perspectives as they relate to this study.

I am an Immigrant Muslim woman from the Middle East. This brought strengths to the study because I believed these mothers and their girls were more open and relaxed to talk with a researcher who knew about the Middle Eastern Muslim culture than talking to an outsider. In addition, I was familiar with some types of the mother-daughter relationships within Muslim and Middle Eastern communities; yet, I was opening myself as a researcher into the meanings of new findings which provided the possibility of “genuine learning” (Patton, 2002).

On the other hand, I brought weaknesses to this study. Knowing that I am an immigrant Muslim mother from Palestine, some mothers and their adolescent daughters may have hesitated to tell me the “truth” about their relationships and gave Islamic, Middle Eastern, and socially desirable answers. Additionally, being familiar with the “typical” mother-daughter relationship in Islam and in the Middle East might have biased me, made me judgmental in some cases and limited or influenced the quality of the study.

Biases and Expectations

I expected that immigrant Muslim mothers’ health values would be influenced by their religious and cultural values, and that adolescent daughters would be very close to their mothers, and their health behaviors would be shaped by the mother’s religious and cultural values. To overcome the risk of reactivity, I showed self-reflection and honesty with self and others. My efforts were directed to present the participants’ own words and my own descriptions and

interpretations which allowed the readers to have their own conclusions about the phenomenon (Patton, 2002).

Dealing with my Biases

The rigorous data collection and the analytical procedures mentioned previously, like triangulation, minimized the effects of my biases. Every researcher whatever the research method brings preconceptions and interpretations to the study (Patton, 2002), and so there should be personal preparation that will affect the quality of the study. I tried to have “empathic neutrality” while interviewing the participants; I was caring and interested in listening to their stories, but neutral about the content of what they revealed.

I also dealt with my biases with conscious and committed reflexivity; reflecting on and analyzing how my perspectives interacted with the participants’ perspectives and by using the verification and validation procedures necessary to enhance the quality of analysis and thereby the quality of the whole work (Patton, 2002). The trustworthiness of the data is attached directly to the trustworthiness of the person who collects and analyzes the data (Patton).

Chapter 4 - Results

The analysis process revealed that health values of immigrant Muslim mothers in this sample were greatly shaped by their religion and culture of origin. In addition, these mothers' health values were influenced by the dominant new culture. Together the three factors; religion, culture of origin and the dominant new culture influenced how immigrant Muslim mothers share their health values with their American Muslim adolescent daughters through the mother-daughter relationship and their maternal practices: availability, monitoring, communication and behavior modeling. The findings also showed that American Muslim adolescent daughters' health behavior was shaped by how they perceived their mothers' health values and maternal practices. In this chapter I present the findings for each research question by providing the emerging themes and subthemes and textural descriptions.

Research Question #1: How does religion influence immigrant Muslim mothers' health values?

The findings showed that, when asked to define healthy behavior, the eleven mothers described religion as an important factor in shaping their health values regarding eating behavior, physical activity, and drug use. In answering the question some mothers mentioned that a healthy behavior was what religion asked them to follow because Islam asked them to follow behaviors that would not harm them. As participant # 110 mentioned, "First according to religion of course, of course religion will not harm us, and then if it is harmful to us or not." Religion in this study was addressed as religious practices and beliefs. However the daughters in this sample did not address religion as a factor when I asked them to define healthy behavior.

Religious practices

Eating healthy and staying active (theme)

Immigrant Muslim mothers in this study mentioned that attending the mosque and the Muslim community centers had a positive influence on their health values. One of the participants (# 107) talked about how attending the mosque, the Muslim gatherings and celebrations made her always feel healthy. In these gatherings usually each woman would bring a dish from her country of origin and most of these dishes would be healthy. This mother explained her experience in attending the mosque:

Yeah, I believe [it is a] positive influence. Yes, because when you are with a community you have to go there on time, you will be active that make you physically active, mentally active, you have to be prepared time ahead, you will be more organized and this will organize your life.

For the daughters this theme was not as clear as with their mothers. Only one daughter (# 110) mentioned that the Islamic center she attended might try to encourage the Muslim girls to swim: “Sometimes the Muslim community rents a place for girls only, and all the girls go there, and we go swim. Sometimes they have that every week, so we have opportunities.”

Religious beliefs

Eating behavior. No pork, ham, nor gelatin (theme)

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 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. (This indigenous term was used throughout the mothers’ interviews.) As participant #101 mentioned, “You know we are Muslims. We don’t eat ham and pork.” They mentioned that they were raised on these values by their families back

home since they were very young. The majority believed that this was the main influence of religion on their eating behavior. Participant #103 said, “On the other hand, we don’t eat ham, pork, gelatin, and we don’t drink alcohol, I mean, it is more, yeah, that’s all about it.”

All the daughters in this sample indicated that they did not eat pork because it was prohibited by Islam. Participant #209 explained how religion influenced her eating behavior: “Yes, yes that also like has a large influence on our life. We don’t eat pork. Or like you ran into something that is touching pork or bacon, you don’t eat it.”

Consciously following religious ideals (subtheme)

Some mothers showed how they also were influenced by the teachings of Prophet Mohammad in their eating behavior; what and how they were eating.

It has a great influence actually when it comes to eating behavior. You don’t eat, you don’t gorge yourself. That’s one thing. You don’t eat, you’re kind of moderate what you are eating, and how you are eating, because there are some things that, for example, very simple, you know, religious wise. You are not allowed to eat like pork so you have to kind of take this into consideration. (#108)

Not following religious ideals (subtheme)

When it comes to “the how” of eating, one mother mentioned that she knew about these religious values, but she did not follow them all the time (participant # 103): “No I don’t follow that all the time [laugh],” Or, as another participant (# 110) explained,

Religion doesn’t have anything to do with food actually, like except we don’t eat pork and we don’t drink alcohol. Otherwise we eat everything. Sometimes I may say to my kids, “Third for food, third for water, and third for air.” This is what our prophet said. But we don’t follow this in our life, we just say it.

Some mothers explained that they were following these values “of how” not because of religion, but because they knew that these were healthy behaviors and would protect them from

diseases. Participant #109 mentioned that she did not know about these teachings before she heard her brother-in-law speaking about them.

Being conscious consumers (theme)

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.” One mother mentioned that if she bought candy for her children, she would be careful and pay attention to the ingredients to be sure there was no gelatin in the candy. 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.”

Using Halal products (subtheme)

Mothers were different in their values regarding eating Halal or Kosher foods. One mother (#108) mentioned, “As far as, I mean, that’s health. You are always aware what you are going to eat. I don’t do the halal thing. I don’t subscribe the halal, but I am conscious of where my food comes from.” On the other hand, another mother (#107) said: “Sure, we pay attention a lot to any product we buy. We don’t buy any product with gelatin, or pork, or any alcohol. It should be halal.”

The daughters showed that they were conscious consumers regarding what they were eating, but doing the Halal products was not clear in their answers. Some daughters talked about how they calculated the number of calories in their meals. Participant #207 said, “You can’t, you

have up to 2000 calories. You can't, if you eat more than that, so you will gain weight." Another girl described what they should include in their food and what they should not:

I think you need to have a balance of um things that, or kind of what your body is asking for. You never go on any crave, a chocolate chip cookie. You might crave pasta or salad that they have certain nutrients to your body needs. Um, so to me it is a balance of your vegetables, your fruits, and your meat, and your hydrates. (#208)

Physical activity

Immigrant Muslim mothers in this study showed variety in their values regarding physical activity and showed diversity in how these values were influenced by the religious beliefs in Islam.

Dressing modestly while exercising or swimming (theme)

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.

Daughters in this study indicated that they would dress modestly when doing track and swimming. Daughter #201 described how she would dress for swimming: "We swim in under shirts and then t-shirts. It is kind of like a lot of clothes, but we're used to it." Daughter #209 (her mother was originally from Lebanon) mentioned that dressing for swimming was never been a problem for her: "I mean like I was always able to wear everything else, and to be in the pool and I can wear swimming suits, and I can go to mixed pools and stuff and it is never been an issue."

Avoiding mixed pools and fitness clubs (theme)

In addition, exercising in gym clubs with boys or men and swimming in mixed pools was another issue. In order to avoid the issue of dressing and going to mixed gym clubs, one mother (#101), who was diabetic, mentioned that she walked and/or ran in the parking lot close to her house: “So I need to do some exercise, you know, at least walking or running. We have, behind our house, school parking for the middle school here. We go there almost, maybe two times a week, and during school days we go on weekends.” One participant (#102) explained that she swam when they had their own pool in a previous house, but now they were living in a house which shares a pool with the entire neighborhood. So she stopped swimming because she did not want to swim in mixed pools: “I know I am not a swimmer. I started learning in that house, but I don’t go outside to swim.” Another participant (#111) said, “I try to make it regular. We, the three of us, have a membership in a gym center, which is just only for women. So it is more comfortable than other centers for us, you know, to exercise.”

Some daughters also showed that they avoided swimming in mixed pools. As #201 explained:

Sometimes like we go and we sleep over in our friends’ houses or something and they usually have neighborhood pools, and they were like closed at night, but we just like sneak in ‘cause nobody is there. And we just swim like in regular clothes like shorts and like a tank top. You know, it is like dark and nobody’s around.

Implicit influence of religion (theme)

Some mothers mentioned that they were exercising because this will help them stay healthy and protect them from different diseases. Participant #105 mentioned, “No, I don’t think it is religion. When I exercise I don’t think about religion. We exercise to stay healthy, keep diseases away from us and live longer. It is in our religion, but I don’t think I exercise because of that.” However, the prophet’s teachings were included in their explanations when I asked them about the influence of religion on their physical activity. “Not really, no. I don’t think religion

has a lot to do with that. It is just that I try to be healthy, because it is just, you know, the famous saying of prophet: ‘You have to be healthy, so your mind will be healthy.’”

Drug use. No alcohol (theme)

All the mothers mentioned that they did not drink alcohol because this was forbidden in Islam and they were raised on these religious values. “You know, we were raised on these values. My family raised me on these values, all my family members, and we don’t drink alcohol” (#106). In addition to religion influence, some participants tried to explain the negative social consequences from drinking alcohol. Participant #105 said, “Okay, religion, we are, sure, we don’t eat pork or drink alcohol, and you know we see other people who drink alcohol and what happens to them. Thanks God, we are following our religion.” Other mothers showed that they were aware of the negative health consequences of drugs and alcohol. They described health facts of drinking alcohol: “That’s because I knew from when I was very young that these are not healthy behaviors. And of course religion adds to that, you know. It is prohibited in Islam to drink alcohol... So I never tried alcohol” (#103).

This theme was clear in the daughters’ explanations regarding the influence of religious beliefs on their alcohol use. The daughters did not drink alcohol because it was prohibited by religion. As #211 explained, “No, that’s definitely like something that religion influences. Like most people here will do alcohol and pork, but those, I think, are the two main things that influence, because we don’t do that.”

No cigarettes (theme)

When it comes to smoking behavior, 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.

Explicit influence from religion (subtheme)

Some mothers said they did not smoke because it was forbidden by Islam. “I mean for drugs and smoking and alcohol are a big NO...according to religion” (#109). Only one daughter talked about how religion prohibited smoking. “I think smoking is like one of the most disgusting things It is not my type of thing, I don’t do that. It is not part of my religion. It is not part of my, you know, how I grew up” (#201).

Implicit influence from religion (subtheme)

Other mothers mentioned that they did not smoke because religion prohibited any bad behavior 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 behavior is forbidden by religion. This subtheme was clear in the daughters’ explanations as well. One daughter (#206) explained, “Like no smoking. Why? Because it is harmful for our bodies, and we respect our body. We care about it.”

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). Immigrant Muslim mothers showed that their health values were also shaped and influenced by their culture of origin. So the next factor that will be addressed in this chapter is culture of origin.

Research Question 2: How does culture of origin influence immigrant Muslim mothers' health values?

Culture of origin played a major role in shaping immigrant Muslim mother's 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. In answering the question about defining healthy behavior, one mother (#104) from Palestine mentioned that it rested on how she was raised by her mother back home: "How we were raised, I always tell my daughter about, always, always say how my mother raised us." Interestingly, when her daughter defined healthy eating behavior, she said: "Because I guess my mom and dad said this not good for you and it is better for your health to eat from home."

Difficult to separate religion from culture of origin (theme)

Other mothers mentioned that it was hard to separate the influence of their cultures of origin from religion on their health values. For example, when I asked a mother about what shaped her health values, participant #109 from Lebanon explained: "Again, if you want, culture and religion go hand in hand." Interestingly, the daughters' answers about the influence of their mothers' culture of origin on their health behaviors did not indicate that they noticed this overlap.

The overlap between culture of origin and religion was clear when the mothers talked about their values regarding smoking behavior. 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." Another participant (#105) from Syria explained, "I feel sorry about those who are smoking. There, they know that smoking is harmful, and it is prohibited by

religion, but they smoke.” 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 behavior was not forbidden by religion according to their values.

Culture of origin health values ranged from conservative to liberal (theme)

Various countries from the Middle East have different cultures and so there are diverse cultural values regarding health behaviors. Countries like Lebanon and Egypt are known as liberal countries in the freedom they give to women. On the other hand, countries like Jordan and some Gulf countries (e.g., Iraq) are known as conservative regarding what is available for women and girls. In between we may see other countries from the Middle East, such as Syria and Palestine, who are considered moderate for women.

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. Participants used “argile” or “shisha” when talking about smoking water pipes. These health values and behaviors were greatly shaped by country of origin. In Lebanon, women care a lot about their appearance and work on losing weight to stay in shape. It is a liberal country compared to other countries in the Middle East when it comes to letting women swim and attend gym clubs and in giving them the freedom to make healthy choices. Her daughter (#209) also showed that she was liberal in her health behaviors; she went to mixed gym clubs, she swam in mixed pools, she dressed in “American swimming suits” and she used shisha.

On the other hand, immigrant Muslim mothers from Iraq, Kuwait and Jordan showed conservative health values and behaviors. These mothers mentioned that in these countries there

were cultural barriers that limited the healthy choices women could make. One mother (#107) from Kuwait explained how it was not allowed in her culture to walk by herself to stay active:

The culture there, the girls can't have activities. Now the world changes, but in my time, most of the Middle Eastern families they were very strict. Their daughters can't go out by themselves, so we just sit home 24/7. Here in the U.S., if I feel like I want to walk, I just like put my training suit on and go walk in the street, without need to ask my dad for his permission, my mom for her permission, my big brother, and then the next brother. You have to get the permission of the whole family and then they will say, "No, stay home."

The daughters of the women from these conservative cultures showed that they also were conservative in their health behaviors. They went to women's gym classes with their mothers, they dressed modestly for track and swimming, and they did not swim in mixed pools.

Participant #210 mentioned: "I'd rather wait till there is no one and then I swim." or did not swim at all.

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. The daughters whose mothers were from Syria and Palestine were as moderate in their health behaviors like their mothers, but the daughter whose mother was from Egypt was more on the liberal side. Daughter #204 mentioned, "I do track and I run every couple of days. Whenever I have a day off, I run. I did karate for four years, and I did volleyball for a couple of some years. I usually like playing outside with my sisters, that kind of activity."

Eating behavior. Cooking traditional meals (theme)

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. One mother (#104) from Palestine mentioned that she was cooking these traditional meals everyday. If she did not cook, she would feel bad:

Yeah, I am till now influenced by the old culture...I will cook these meals for them. If I didn't cook like for two days I will feel so bad, very bad, bad, bad. I have to cook makloobeh, mansaf, mlukheieh, all the Arabic food. They like it a lot. I have been here for 20 years. I didn't change. I like cooking these traditional meals.

The majority of the daughters mentioned that they loved and enjoyed these meals and they thought they were healthy. However, mothers showed different perceptions for these traditional meals and this also influenced their daughters' perception of these meals.

Positive perception of traditional meals (subtheme)

Eight mothers explained that these family traditional meals were healthy and that is why they were still cooking them even in the new culture. The mother from Syria (#106) explained, "Yes, I think what we cook back home is very healthy." One mother mentioned they were healthy, but she made some changes in the new culture, like adding salad to the meals.

Although the majority of mothers gave a general expression for the traditional meals they were cooking, like "Middle Eastern" or Arabic food or meals, there were two participants who tried to show that their families were different from others in their country of origin. One participant from Lebanon (#109) explained that she was following healthy eating behavior because she was influenced by her parents back home who were different from other families following unhealthy life style in her country of origin:

I took it from my family back home before I got married. "Don't eat food over food." Like if you eat chicken, just eat chicken... I was raised on these values...Some people there may have fries everyday. You know, things like that.

Another mother from Syria (#102) mentioned that her mother is her model for eating behavior: "So, I learned from my mother. She was always cooking. And, as I said, more like, you know, I cook more like her. So it was like lots of vegetables, less meat, you know there is rice ...So, you know, I grew up in this environment." Her daughter (#202) also had a positive

perception of her mother's traditional meals: "But she will be sure like every day we do, she like always cooks Arabic food. It is usually healthy and I like it."

Negative perception of the meals (subtheme)

A participant from Iraq mentioned that she only cooked traditional meals on occasion because they were not healthy "Yeah, about the meals back home, we love them. We eat them on some occasions and that's all. I don't cook it everyday." Only one participant from Syria thought that these meals were not healthy at all and so she made big changes on the way she was cooking for her family. "No, our eating behavior is not healthy in the Middle East. Really, the way we cook meals, the ingredients we used to put, it is not healthy at all. They love using fats and butter. Now I am not using these things" (#105).

Some daughters exhibited a negative perception of the traditional meals. Daughter #201 talked about the Arabic sweets her mother used to make and how they were unhealthy: "Yah I mean she cooks pretty good, healthy. Yah, I mean when it comes to Arabi sweets not really." Other participants mentioned that sometimes they would not like what their mothers cooked and would eat anything else or ask their mothers to cook American food. Participant #211 mentioned, "For the most part I'll eat what she makes, and if not I will make a peanut butter sandwich or something like that, you know."

Preparing three meals a day for the family (theme)

Some mothers talked about how they tried to prepare the three meals for the family and sit at the table for the three meals. One mother from Kuwait (#107) explained how she also liked to have all the family members sit together as a family to have these meals:

We have to set up the table and eat at least two times a day. Either breakfast or dinner or late breakfast, it is like mid between breakfast and lunch, and dinner. So we sit at the table and eat together and talk...In the presence of the family, in most cases we have

other family members, like my mother will visit, my brother will visit, my uncle, family. We like to sit as a big family together around the table.

Some daughters talked about how they enjoyed sitting together for the family meals.

Participant # 101 mentioned that she always enjoyed what her mother cooked for lunch because they were healthier than meals from school. Daughter #208 talked about these family meals:

I think she, um, she tries to be at home a lot and to make dinner everyday and have us sit down and eat dinner together, um. And I think that's, I mean like, have me talk better and she'll tell me what she wants to do with me and be doing that together. I think that is a mixture of culture, how the woman should do this, and this and also just parenting.

Physical activity.

Practicing what was common for women to do in their culture of origin to stay active
(theme)

Mothers in the current study showed that their physical activity was greatly influenced by their cultures of origin. The majority of the mothers ended up practicing what was common for women to practice to be active back in their countries of origin.

Acceptable activities for women (subtheme)

Immigrant Muslim mothers practiced what was accepted by their culture of origin to stay active. For example, when it comes to swimming, only two mothers mentioned that they were swimming, but not regularly. The reason why the majority did not swim was explained by a mother from Iraq (#111):

Yeah, back home it is uncommon for the girls to exercise, or attend swimming classes, or practice.... It is uncommon, you know. This is first because parents are afraid. They care about their daughters, because of our society. And second, these are cultural values and habits.

Some daughters in this study showed that they practiced what was accepted by their mothers' culture of origin values. Daughter #201 loved to do track, but this behavior was not common in her mother's culture of origin. So she stopped practicing it.

Commonality of physical activity (subtheme)

It was clear to some mothers that they ended up practicing what was common for women to do to stay active in their culture of origin. For example, one mother (#102), who was trying to be active in the new culture by walking, mentioned: “I think I was influenced by my mother, you know. She was very healthy, walking and doing everything by herself.” Another 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 participant here mentioned that she did not want to blame her parents for not raising her to be more active than she was because as she explained this was caused by cultural barriers.

Drug use.

Practicing what was common for women to do in their culture of origin (theme)

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 behavior for women in their countries of origin. Participant #109 explained, “I mean, the shisha has to do with the culture back home.” These mothers said they were not addicted to its use and they only participated for fun. “Yeah. Yeah. Argile, I do it when my friends come over. I will do it. I don’t do it all the time, but I do it for fun...Every once in a while, I am not addicted. I am not a smoker” (#110).

Participants showed how their values regarding smoking were shaped by their families back home and how they were raised. On one hand, one mother (#103) mentioned that she was

not a smoker because: “Noone in my family smokes, my father or my mother, or any one, they don’t smoke.” On the other hand, the only smoker among the mothers mentioned, “Yeah, all my family members, my mother, my aunts, my uncles, their daughters [all smoke]. So I have a family influence.”

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).

The drug use for some daughters (N= 3) was influenced by their mothers’ culture of origin. The daughters mentioned that they used shisha or argile with their mothers because it was accepted by her culture of origin values and it was “in style.” “Yes, we will have shisha together. Like, most of the time, like it is part of the culture. It is part of the Arab culture. So it is kind of one of those things that are accepted by the culture” (#209).

Research Question 3: How does acculturation in the U.S. influence immigrant Muslim mothers’ health values?

Immigrant Muslim mothers made some adjustments and changes in their health values when they moved to the U.S. When answering the question about defining healthy behavior, a mother from Egypt (#108) explained that a healthy behavior has a goal or a purpose that a person is working toward: “I always believe there has to be an ultimate goal and you always have to stop and check if you are actually going that direction or not.” The mother also mentioned that while following any behavior one should have a set of values, morals and a set of goals to achieve her purpose. Her daughter (#208) defined healthy behavior in this way: “And then as far

as health, just kind of think, what is best for you other than what goes, you're, your religious and cultural values and is it is just what best for your body." These quotes illustrate that the mother and her daughter were influenced by the American values and were showing the subjectivism or the individualism in their definitions for healthy behavior. They showed that their health values and behaviors were shaped more by their own goals and desires more than by religion and or culture of origin.

Becoming more religious in the new culture (theme)

All the mothers mentioned that religion greatly shaped their health values in the new culture. The majority of the mothers in the current study showed that they became more religious in the new culture than they were in their cultures of origin.

Made the separation of culture and religion more clear (subtheme)

Six mothers mentioned that they were more religious in the United States than when they were in their country of origin. "For me, thanks God, I mean, thanks God, on the contrary, I feel I am more religious here, more than back home" (#101). Even those who were moderate when it came to religiosity mentioned that religion had big influence on them.

Um, I left Egypt when I was 21 and that was a long time ago. Um, so I am actually more, I am actually shaped more by the values here, but except the values in Egypt when where I grew up. Um, I was exposed to them in the formative years when I grew up so they definitely have deeper influence on me... So I have my own values and my own beliefs. These do not necessarily have to do with the culture per se as much as it is by religion. (#108)

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.

Even we Arabs here in the US, I mean, people who have traits, they don't care. "We are in America so we will behave like Americans." Other people are extremely religious. So, for me, it is hard. It is against me. When I talk to somebody about it I will say we are swimming against the waves. (#111)

Another mother (#102) mentioned how in the new culture she learned about the “real Islam,” separated from the influence of cultural values and traditions:

I think overseas was more all about culture. But here, thanks God, we got the chance to learn about Islam, about the real Islam. Over there it is what TETA said, and what Jedo said, what neighbors said. But here, thanks God, we started, you know, reading all these lectures and attending all these lessons. So everything to me according to Islam Haram and Halal, it is not like Aeb.

The majority of the daughters indicated that they were more accepting of the religious values than the culture of origin values. Daughter #202 mentioned that “I feel like, overseas, in general, they focus more on culture, but over here, we focus more on religion.”

Retaining cultural values (subtheme)

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. Participant #108 explained, “Religion has a huge influence, I think, in the way I behave, but religion is practiced in my mind with a of little bit of cultural twist.”

Leaving some cultural values behind (subtheme)

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. As one mother pointed out, “There was no choice. I left out many cultural values, as I mentioned, not religious” (#101).

A few daughters accepted their mother’s culture of origin values. Participant #201 explained how she perceived some of these values positively:

I think it is mostly religion first, and then I feel like she also ties old culture with it. You know, like she gives into some stuff. You know, she just goes on small things. But I feel like the main big things in our culture, she tries to keep us close to them. You know, they

are good stuff, so we don't really go against them, you know. Just the small things we don't get along, like we have different opinions about them.

Cultural value conflict (theme)

Muslim mothers described that they have value conflicts with their daughters and they used different parenting practices to resolve this conflict. Participant #106 described this struggle:

The culture here is influencing, sure, it is influencing, sure. You know, in my opinion, I don't know your values and habits, it is hard to share these values. You need a specific style of communication to convince your daughter. It is hard and sometimes she is not convinced and will follow the behavior, but I feel that like she is forced to do that and she doesn't like it.

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 behavior and drug use. However, some mothers talked about conflicts regarding their daughters' physical activity. For example, one of the mothers (#101) did not want her daughter to practice track and she did not support her, because she thought that this was not necessary. Therefore, in the end the daughter quit this sport. 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 about this and cook different meals for them.

The daughters in this study mentioned that they might have value conflicts with their mothers regarding the mother's culture of origin values but not religious values. Participant #209 pointed to this:

Mostly cultural, I think um, “You are not allowed to spend the night in other people’s house.” Because she is kind of, “Why don’t you bring her to our house?” And that sort of thing. “You should stay home with the family.” Um, so, to me, that is more of a cultural thing.

Daughter #201 talked about the conflict she had with her mother because she did not want her to practice some sports:

For physical activity, I think we, they have, their mentality is a lot different than ours. We like, I like, to get involved in stuff and sports and stuff. For example, biking. They’re, my parents, gonna stick for some reasons, and I think I love biking and stuff. For some reason they don’t in their culture, Arab culture. It is not seen as something positive, you know. I don’t understand that, you know?

Positive perception of sex education at school (subtheme)

Sex education is not available in many countries in the Middle East. But in the United States, it is taught in public schools. Immigrant Muslim mothers might see this as going against their religious and cultural values because the majority of them, if not all, knew about sexual behavior only after getting married or before that with a bit of information from their mothers.

Mothers in this study were different from each other regarding their opinion about having their daughters attend sex education classes at school. Some (N=7) mentioned that they did not mind if their daughters attended these classes and explained that knowledge was power and it would be better if their daughters had the information from school instead of other untrusted resources or friends. One mother (#108) explained how she thought these classes would help her daughter made better choices:

I think it has a lot to do with the fact that when you know more you can make better decisions. It is the ignorance and making something a taboo and not talking about it. That’s what makes it more attractive. So I just want things to be often, just the behavior, I want her to understand what the behavior is and why it is not acceptable, or why it is acceptable, whatever the case is.

Other mothers (N= 2) mentioned that they would talk to their daughters about this topic themselves, because they felt that they could provide their daughters with the needed information. One of them, mother #110, said she did not give permission to her daughter to attend sex education classes. The other mother (#107), her daughter was 14 years old, did not have sex education classes in school yet, but the mother was planning not to let her attend these classes.

Sex education, I talk to her about it. I know what they will talk about. They will talk about the man, the woman, and how they have sex. But they will talk about using protection. I told her, "I will teach you about sexuality in my own way." (#107)

One mother (#105) mentioned that if the classes were not mixed she might let her daughter attend these classes. (I found from the daughter that she had taken these classes).

The majority of the daughters described a positive perception regarding sex education classes at school. In fact, most of them laughed when I asked about sex education. Some of them (N=3) did not have these classes yet and there was no problem for them in attending these classes. "There is nothing really bad. You just you know the effects and the diseases that happen when you have sex" (#207). Others who had these classes found that they gained knowledge from them about sexual health. Only one participant mentioned that she would not have sex education classes because she had enough about sexual health in Biology classes.

Eating behavior.

Red lines (theme)

All the mothers mentioned that they did not change their religious values regarding eating behavior 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.

They were raised on these values back home:

No, no, I will never think to change like religious health values. I will never drink nor try ham, no way... I never think to do that, although I am not very religious. I pray. I fast. And I believe in God. But these behaviors, we were raised, you know, to follow these values.

None of the daughters discussed crossing these red lines. They all seem to accept and follow the religious rules about eating. Daughter #205, when I asked about how she thought Islam influenced her health behavior, said, “In Islam it tells u, like em, well, it tells us, encourages us to take care of ourselves, and to exercise, eat healthy, not to smoke, not drink, not eat pork, and all this is good for us.”

Making Changes (theme)

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.

Eating at Restaurants (subtheme)

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. “But now I am busy and working, and this life, and by time, I feel I am lazy. I don’t do that anymore” (#101). Participant #103, a physician, mentioned that her life style was different from the mothers in her old culture, and so she could make only one meal a day for her family: “I think I am influenced by the American culture, and our life style is influencing our eating behavior. I don’t cook too much at home. I try but. Our main meal is dinner, not lunch as it is back home.”

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, Participant #110 explained, “I go out for dinner when it is like we need to go to a dinner like a family. Once a while, like every two weeks or a month.” Only three mothers said that they ate junk foods and they usually would feel bad after this, because they knew it was not healthy. One mother (#102) explained that, although she ate junk food with her children, they never tried the “the extra thing” in the meal or in the drink. Another mother (#110) mentioned that she used to eat junk food because she had 6 children and it was easier to hang out with them than to cook at home: “You know with the kids, sometimes it is easier to go out and feed them MacDonald’s, sometimes, and come back when they were all young, but now I don’t.”

Most daughters (N=9) talked about how they would eat at restaurants and eat junk foods with their mothers, families and friends. Participant #208 talked about this: “Um, we used to do, if my dad was in town, we’d go out and have dinner and some ice cream and we might go and grab KFC.” Another daughter (#209) indicated that she was trying to follow healthy eating

behavior: “I mean not 100%, I have few like MacDonalD’s and Tacos, things like that. But like 5 days of the 7 days of the week I follow a good healthy behavior.”

Negative influence of the new culture on the mothers’ health values (subtheme)

Two mothers mentioned that they were not as healthy as they were in their country of origin. One mentioned that she was not eating food as healthy as before:

You know there we don’t know healthy or unhealthy, but I believe our food is healthy, even the fats we are using back home it is healthy. The oils are healthy and our bodies need them. I believe the food sources there we ate healthier than here. Here they have green houses and more hormones.”

Three mothers mentioned that they were not as active as in their home country. This could be because of the weather in their state: “Because of the cold and hot weather here, so I feel I am not active as before. So most of the time I am at home.” It also was attributed to being busy or because of the transportation and the whole life style in the United States:

Here, no, for example, when I go to work I will park in the closest spot to the garage. I will use the elevator. If I go to [store name] I will keep looking for the closest spot to park. [I use] drive through for coffee, drive through for the bank, drive through. I mean, if you think about it, it is bad, eight hours under sitting on the chair at the computer. (#109)

Positive influence of the new culture (subtheme)

On the other hand, some participants mentioned that they were following healthier behaviors in the United States compared to their behaviors back home regarding eating behavior and physical activity. Two mothers mentioned that their traditional meals back home were not healthy at all and they were preparing healthier meals in the new culture. “Now I changed a lot in these meals. Now I am not cooking many [traditional] meals because they are not healthy” (#105). Participant #106 said that back home they did not have choices when it came to their eating behavior, but in the new culture they had different choices. She described the option of buying organic foods. Five participants mentioned that they were more active here. After I came

to this country actually I started going to gym, and I started swimming. So it is just more em feasible, and it was more acceptable, and I had the abilities and avenues to do whatever I need to do. It was more difficult in Egypt. (#108)

The majority of the mothers in this sample explained that the new culture increased their awareness about healthy behaviors regarding healthy eating behavior, physical activity, and smoking.

It has big influence, really it has. You feel the whole society encourage you to stay healthy, and exercise. And the ads on TV, you see people walk and exercise everywhere; they remind you about exercising in cold and hot weather. They encourage you to be active. Healthy food choices here also, like organic foods, this encourages you, and you have choices. (#106)

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 behavior because of the laws and the bans the government had for those who smoked. She explained that it helped her to start thinking about quitting smoking:

Yes. Because here in the US you cannot send your son to buy you a box of cigarettes. You have to go. [They] need to prove that there is an adult buying the cigarettes. So this is like, put me sometimes when I run out of cigarettes, you may feel like to go out. I have to stay without smoking until I feel like to go out. So the rule, this thing will cut the amount that I smoke. When I go out to the malls and restaurants I cannot smoke there also, so yay. (#107)

Some of these mothers mentioned that they were comfortable in the new environment and that they were trying to take the positives from the American society. They felt that one of the factors that was encouraging them to follow healthy behaviors was the freedom they have in the United States.

We here, it is very easy to go to gym. You feel free. There are no restrictions, more freedom in the gym, you know, nobody is looking at you. You know, back home they think if a girl goes to gym all the boys will be looking at her. I like it here. Nobody looks

at you. Back home they look at me. Here it is very nice, nobody looking at you, no harassment at all. It is very nice. I like here. I took the beautiful and nice values. (#104)

They also mentioned that in the new culture they followed certain behaviors because they were healthy behaviors, not just because they were accepted by the culture.

Yes, yes, too many things I am more comfortable with here if I was over there. I have the freedom to choose things without being, not because I have to it, because everyone is doing this. No, thanks God, I can do what I want, without all the neighbors, you know, like overseas. (#102)

Daughters talked about the positive influence of the new culture of their health values.

The majority talked about how the new culture increased their health awareness and educated them about different healthy behaviors regarding eating behavior, physical activity and drug use. They mentioned how this culture encouraged them to eat healthy, stay active and avoid smoking. Participant #206 talked about fitness: “I mean, I like how America does a lot of good things about it, like that specific thing, like, you know, they stress fitness a lot, you know, and being active.”

Research Question 4: What is the general nature/quality of immigrant

Muslim mother-daughter relationships?

All the mothers explained that their parenting practices in the new culture were shaped by religion, culture of origin, and the dominant new culture. But they showed variety in how these factors influenced their parenting, especially when it comes to the new culture influence.

Participant #108 described,

“Uhh religious values are veiled in cultural values, but it is mostly the religion that affects most of the things that I believe in. Um when I do let things slide, that is the new culture affecting me.”

The mothers talked about how they tried to be close to their daughters, listen to them, provide them with advice, be flexible and supportive, give them freedom, and trust what they

would do. Participants described different types of relationships with their adolescent daughters. Six mothers felt that they had good and positive relationships with their daughters; four mothers mentioned that it was changeable; and only one mother mentioned that they did get along well.

Close relationships with daughters (theme)

Those who felt that they had a positive relationship with their daughters indicated that they were close to them. Mothers would cook healthy traditional meals with their daughters, go to the gym together, and some prepared argile and smoked together. Participants tried to be close to their daughters because they felt it was the way to encourage their daughters to be open with them. “I feel I am very close to them and they feel the same. Yeah, especially the young daughter – too much. I mean, she will tell me everything, I mean.” Mothers also tried to be friends with their daughters, good listeners who tried to answer their daughters’ questions, because they did not want them to look to other resources.

So you have to, I mean, to be their friend. Yeah, you should try to be their friend, here they want an answer. If they ask you, they need an answer and you should be honest. So you should give them the right answer. For me, I raised them to come to me and ask me and I give them the right answer. I don’t want them to go ask friends, and they understand that. (#111)

In addition, mothers in this study described provided health advice to their daughters. Participant #101 said, “She always asks for my opinion, and she always accepts the advice and she has no problem in this with me.”

All the daughters reported that they perceived their relationship with their mothers positively. Ten of them mentioned that they felt they were close to their mothers, and only one (college student) mentioned that although they cared about each other deeply, she and her mother were not close enough. She said that they were working on that. Only two of the interviewed daughters described that they were friends with their mothers. “Yeah, very close, we’re like best

friends. And every time like something happens in my day, I will go and tell her, or somebody gave me something, you know, I will tell her. She is always excited about it, you know” (#206).

Mothers talked about how they trust their daughters and have given them freedom when they felt they were responsible and could make good and healthy decisions. Some mothers mentioned that it was okay for them if their daughters hung out with their friends and ate in restaurants because they trusted that they would make healthy choices. But they also mentioned that they would be watching their daughters because in the end it is all their responsibility; so if the daughter followed a behavior that was not accepted by the family rules, than the mother would realize that she was not successful in raising her daughter.

Supportive relationships with daughters (theme)

Mothers emphasized that they were supportive, flexible and open minded with their daughters. They indicated that they supported their daughters to stay active by doing track, walking, running, and swimming. “For my daughter, I have no problem for swimming, and she goes for track... I will always support her, always. I will always say okay for sports. Any sport for my kids, I will support them” (#104). Some mothers were flexible regarding their daughter’s dressing for swimming and some of them were open minded and tried to find “Islamic swimming suits” for their daughters “If she wears good [dresses appropriately], she could swim... Like there is a swimming suit that covers all the body” (#109). Participant #107 said, “So we find a solution for this, she wore a full-cover swimming suit. When she goes to swim, she will be happy.”

Some mothers were also flexible regarding the traditional meals they cooked for the family. If their daughters did not like these meals, they would try to make some changes from the new culture or even stop making that type of meal and try American food. Other participants

showed that they would eat in restaurants and or even eat junk food with their daughters. The mothers indicated that they did these things to be supportive of their daughters.

But the mothers also made it clear that they were not always flexible. There were times when they remained firm. Participant #101 explained, “I think I have a successful relationship [with my daughter]. Thanks God. I guess I am close to her. I mean in some areas, I mean, I give my opinion and she has to go with it. And at some points I am supportive in what she wants to do.” The mothers seemed to convey that, if the daughter wanted to follow a behavior that contradicted with the mother’s religious or cultural values, the mother would not be supportive. Some mothers mentioned that they will even force their opinion and values on their daughters. This is evident as participant #109 talked about her daughter’s dating behavior:

I mean, for example, if she said she is talking to somebody, I will listen, take and give. If she said she is in love with an American guy, I will say, “NO!” And I am gonna fight for it! I will give my opinion and say, “NO, NO, NO, NO!” And she knows it. For example if she said I know a guy and I am talking to him, and I know she is not gonna cross the line, she is not doing anything, I would be flexible. I mean it is relative.

Some daughters reported that their mothers were good listeners, supportive of their decisions, open minded, and flexible. They mentioned that they would go to their mothers for almost everything; in fact, their mothers were often mentioned as the first person to talk to if they needed to know about anything or if they had a problem. Daughter #202 mentioned, “Yeah, usually when I have, when it is like something big or a decision about school or like something important, I usually go to my mom. And most, like, usually she has a good advice, like it is very practical.” They also talked about how their mothers supported healthy behaviors like doing different sports. Participant #203 said, “My mother likes me to do sports, she will encourage me if I ask her. Like, [if I ask,] “Should I do soccer? Should I do basketball this year or not?” She is encouraging me to do them.”

On the other hand, some daughters felt their mothers were not open minded and they had a perspective that prohibited them from going to their mothers for personal issues. For example, #201 said,

Yeah, yeah. I talk to her about almost everything. I feel like she is supportive most of the time. But sometimes our opinions differ, because of culture-wise. Like I feel like that is a barrier. You know, maybe she has a different mentality toward something [than I do].

Other participants felt that their mothers liked to give their opinion about whatever the daughters did and these mothers wanted their values to reflect on their daughters.

Well, it depends on what is this about. Like when it is, like goes against Islam or maybe like Allah didn't say something specifically about it, and she will be like, "Ask Sheikh" or "Okay, ask somebody who is really knowledgeable." She will say, if it is okay, "Go for it." But she obviously gave her opinion. (#106)

Others mentioned that their mothers did not give them enough space. These participants said they usually argued a lot with their mothers, fighting almost every day about value conflicts with their mothers. However, they perceived this conflict positively and said that this was normal, not crazy. They saw it as necessary in order to have healthy relationships.

We do fight a lot, almost everyday, but it is {laugh} okay. I think we are really close. Like I, I think it is good for a healthy relationship. I think it helps our relationship, because when we fight I'll tell her what bothers me and she will tell me what bothers her. It just works out well in the end. Like in the end I always regret it. That's why I think it's a good relationship with her because I don't want to hurt her. I will always apologize to her. (#106)

Mother-Daughter Conflict (theme)

Four mothers talked about how their relationships with their daughters were not stable; sometimes they felt they were close to their daughters, but other times they felt they were distant. Some mothers explained the reason for this gap was the value conflict they had with their daughters. So, if the daughter made a decision and the mother was not supportive because that decision contradicted with the mother's religious or cultural values, then the daughter would think that her mother was not open minded or she was old fashioned. As a result, the relationship

would fall apart and a gap would exist between them. Mothers explained that their daughters wanted them to say “yes” all the time, and how this would not work with them especially if the decisions went against the mother’s values.

Yeah, sometimes I feel we are close. I try to be close. Supportive, ahhh, emm, well, I can’t say “yes” to everything and this is what she wants. There are red lines, there are red lines in the family, and if she crossed them there will be conflict. So, if we agree on values it will be very nice between me and her. You know the same. (#106)

Other mothers mentioned that this distance in mother-daughter relationships could be caused by the stage of development their daughters are in – adolescence. Issues such as identity formation, independence and the social change that occur to their daughters in this stage could explain the conflict. Participant #108 explained, “Um I think we are close, but some days, she is its the age of [needing] independence. That’s the part that really kind of pulls her away.”

Participant #107 mentioned that the reason she was not close to her daughter is because her daughter was raised in a new and different culture. She said that she was influenced by her relationship with her own mother and she explained how, in her culture of origin, mothers were very attached to their daughters. They knew everything about them. But in the new culture the girls were not attached to their mothers. She said they had “restricted feelings” toward them, and they had secrets.

The only mother who mentioned that her relationship was not good with her daughter explained that there were some individual factors that were influencing their relationship. For example, she mentioned that her daughter was stubborn and over time it was getting worse. On the other hand, she said it might be her mistake that they did not have a good relationship because she was always stressed. This was what she said when I asked her about her relationship with her adolescent daughter:

You touched a sensitive nerve... You know, I feel my daughter, ahhhh, the older she is the harder it is to deal with her. She is getting more stubborn than before you know... Sometimes, I try sometimes to get close to her. I sometimes tried, may be it is my mistake, I am stressed and nervous person in nature.”

Maternal availability:

Mothers in this study talked about how availability was an important factor in parenting their daughters in the new culture. They explained that the more they were available, the more they would be able to share their health values with their daughters by preparing healthy family meals together, going to the gym together or even doing shisha together.

Immigrant mothers showed variety in how they perceived the importance of maternal availability for raising their daughters in the new culture. One mother talked about how it was very important to be available any time her daughter wanted her and that was the reason why she did not work in the new culture. Others who were working mentioned they always tried to be available for their daughters when they got home from school.

What I try to do is just be available for her. I am always home when she is home. I even, when I do work, um, 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, you know, kids are back home from school. (#108)

Amount of time spent (subtheme)

Only one mother felt she was spending enough time with her daughter. The other participants felt that they were not spending enough time with their daughters. This was either because the mother had a job or she was busy with other family members:

You know, what makes it harder, I have many babies. She maybe doesn't like it ... They don't leave me alone. Like, if I want to go out with her, she will be, “You come out with me by yourself, don't bring the others”. (#110)

The majority of the mothers said that the daughters had busy schedules, especially on school days. “It is not enough, as I wish; I wish I can spend more time with her. But, for them studying is taking too much from their time” (#101). Other mothers said their daughters were not

willing to spend time with them. Mother #110 talked about how her daughter did not like to sit with her and the other family members:

I think she doesn't like to spend time with us. She likes her room... Yeah, and it has been like this for the last two years now. If I call her "Mommy" she will come help me and go to her room. I am always upset about this. I don't like it. At this age they like to have their own time."

The findings from this study showed that nine daughters perceived their mothers' availability positively. The daughters mentioned that their mothers tried to be available and be there for them whenever they needed them.

Um, but with my mom, I think she, um, she tries to be at home a lot and to make dinner everyday and have us sit down and eat dinner together. Um, and I think that's, I mean, like, have me talk better. And she'll tell me what she wants to do with me and be doing that together. (# 208)

Some daughters felt that they did not spend enough time with their mothers because they were busy in school, or at work, and or at sport practice. Others indicated that they didn't spend enough time together because both of them were busy during the day.

She is definitely available. I don't know that I utilize the time that she is willing to give. Um, 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. (#208)

Two daughters perceived their mothers availability negatively. One daughter (#203), whose mother is a physician, mentioned that she would like to spend more time with her mother:

Sometimes I never have my mom all day, because she is really busy. Like, if I am alone at home with no one. I don't like to be alone, but sometimes I am okay with it, when my Dad and my sister are with me. But I do enjoy like having my mom with me.

The other daughter who wanted more time with her mother said that she did not spend enough time with her mother because her mother was busy with other family members, and they never planned for a time to hang out together with only the two of them. "Sometimes both of us

are busy...Of course, like, we talk and stuff and, like, we have a good relationship, but we don't actually, you know, hang out and make and spend time together. (#105)

Quality of time (subtheme)

In addition, mothers, especially working 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. These mothers mentioned that whenever they were spending time with their daughters they would try to share and talk about their values, especially the religious ones.

Sure, sure, sure, always. I mean I feel like a squeaking wheel, "You have to do this and you have to do that." And so God, I told her, I always remind them. "And if I am not watching you, somebody else is watching you." (#109)

Daughters also talked about the quality of time they were spending with their mothers. Some mentioned that they spend their time talking with their mothers about daily events, cooking together and enjoying family meals, and going to the gym together. In addition, some daughters mentioned that their mothers would try to share their religious and cultural values whenever they were spending time together, like while they were in the car.

Umm. Yeah, it's kind of like when she drives me somewhere, like she will bring up, she will be like, she will talk to me about Islam, and "You have, you know, to do this and this and this." And she will talk to me about like something that is valuable to me. (#205)

Research Question 5: What are immigrant Muslim mothers' health-related mothering practices?

Besides trying to be close and available, immigrant Muslim mothers showed other maternal practices to share their health values with their daughters. These practices were general and included health behavior monitoring, health communication and health behavior modeling.

Monitoring their daughters' behaviors (theme)

Monitoring was a parenting practice emphasized by all the mothers. They believed that when they monitored their daughters' behavior, they would be able to protect them from following unhealthy behaviors or any behavior that contradicted with their religious and cultural values to keep them safe. As a result these mothers family rules to indicate red lines regarding choosing friends, hanging out with friends, using computers, using cell phones, texting messages to friends, eating in restaurants, eating junk foods, and dressing for swimming and track.

The mothers in this sample showed that they knew where their daughters were, what they were doing and with whom they were spending their time in most cases. These mothers tried to encourage their daughters to have the majority or all their friends from the Muslim or Arab communities and hang out only with them. They believed that their daughters would not be exposed to values from the new culture that might influence their health values and behavior negatively.

Only Arab friends, just girls from Arab families. She always hangs out with them every weekend. She goes out from maybe 4:00 pm and returns at 9:00 pm. Each weekend, most of the time, she goes to their houses. I mean, "I am going to Aunt {friend's name} house." We know all of them.

One mother also talked about family rules when it comes to hanging out. This participant believed that her daughter should spend more time with the family. She did not like that her daughter loved to hang out a lot with her friends. The mother tried to tell her daughter that this was not accepted in her culture back home and that she should hang out with her sister or with her mother.

I give her some reasons, but it doesn't make sense to her... She could work. I told her to go work. She could do activities, but going out all the time? Like, if she goes out with her friend 5 times a week, what is she gonna do with her friends? Is it good? What is she gonna do at her age? (#110)

All the daughters in this sample perceived their mothers' monitoring their health behaviors positively. They explained that their mothers always knew where they were, with whom they were spending their time, and what they were doing. Most of the time, the daughters would tell their mothers where they were going ahead of time. They described how their mothers might call while they were hanging out with friends, but they also mentioned that this would not bother them, because they understood that their mothers wanted only to check on them.

She is not one of those type of moms that call you every two minutes, which is good. I like that, but she will check every couple of hours or anything just to make sure I am okay and stuff. You know it is normal, like, she knows where I go. (#201)

Monitoring Eating Behavior

Mothers paid attention to what their daughters were eating. First, the mothers would make sure that their daughters were following the religious values regarding not to eat pork when they ate in restaurants. Participant #110 mentioned that she would make sure that her daughter would stay away from pork because she knew how it looked and smelled. Second, participants mentioned that they encouraged their daughters to eat more fruits and vegetables and to avoid soda and chips. Mother #103 mentioned that she had a rule for snack time: "I mean, they don't eat a lot of snacks compared to other kids. They are allowed to eat snacks after we have, after meals. Your stomach is almost full so you don't eat a lot. That's a habit they got since they are young – snack after food, so you can eat your meal." Third, another mother (# 109) said that if her daughter ate junk food, she would encourage her to stop, because it was unhealthy behavior regarding her body weight:

They eat junk food. They do that, but what I try, again in my mind they still they are still young. They are very active. They work out. And I always tell them, for example, I do mention, for example, "{daughter's name}," for example, "You gained weight, you need to watch your weight." I do tell her that.

Some daughters talked about how their mothers would watch their eating behavior such as if they were eating a lot. Daughter #204 said, “[My mother] will say, ‘Try not to eat too much, because it is not good for you later.’” Daughter #205 reported:

She always cooks at home and stuff, and she encourages us not to eat like junk food and stuff. And she is like, “You should eat this and not this” and so. You know, it is something that she won’t pay attention to, but once she notices that we eat junk food and stuff, she will be like, “Stop.”

Monitoring Physical activity

In addition, some mothers talked about monitoring the amount of time their daughters spent on computers, used cellphones, or sat in their rooms by themselves because they wanted them to be more active. Participant #109 mentioned, “I always like them, like not to sit down at the TV. ‘Go ride the bicycle.’ They have to be active.”

Daughters talked about their mothers’ monitoring their use of cellphones, texting to their friends, and sitting at the computer. “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” (#204).

Monitoring Drug use

Mothers also reported monitoring their daughters’ behaviors regarding potential drug use. Mother #101 mentioned that whenever her daughter returned back home after hanging out with her friends, she would always smell her clothes to find if she or if her friends were smoking: “Sometimes, when they come back home, I will smell their clothes, when they go out in the evening, even with Arab friends. You know, I am still afraid. I trust them, but I am not sure 100%.”

Different patterns

However, mothers showed variety in monitoring their daughters’ behavior in the new culture. Some mothers described that they monitored their daughters very closely. “I have to

know where she is, exactly where she is going, with whom, and when she is coming back, and I know all her friends, like and I know them and their families too” (#110). On the other hand, some mothers were more permissive. One mother (#103) explained that she might know where her daughter was on a specific day, but after a while “I am trying, you know. Like there is always something that you don’t find about it immediately. You just find about it later, but she doesn’t intend to hide information from me.”

The two mothers with college student daughters were the most flexible. One mother mentioned that her daughter visited home only on weekends or when her dad came back during the week. She (#109) also said that she did not know about the daily details from her daughter. “I call her in my way home around 5:00 pm [to ask], ‘Where are you? and What are you doing?’ Sometimes she calls me, we text, and sometimes, if she has homework and she needs help in Arabic, we Skype.” The other participant (#108), whose husband travelled a lot, mentioned that she made a rule for her and for her daughter: “I will tell you where I am , and in return you tell me where you are.”

Although there was monitoring by the mothers, adolescent daughters mentioned that their mothers were flexible and open. Some daughters mentioned that their mothers were flexible regarding eating junk food and or in restaurants. “She’s never been really strict, like, ‘Eat this and this and this.’ But she usually, if I ask her for something like junk food or something like that, if it is too much, she will say no. But she is never too strict about that” (#211). Others also mentioned that their mothers were understanding if they did not like the traditional meals, and they would cook something else for them as daughter #206 mentioned. “If she knows that we don’t like something, then she will avoid cooking it too often. Like if one of us likes, out of the

whole four in the family, then she'll cook it like once a month; but if we all like something, then she'll cook it more often”

Some daughters felt that their mothers were flexible regarding their dressing for swimming: “Yes, I mean, like I was always able to wear everything else, and to be in the pool. And I can wear swimming suits, and I can go to mixed pools and stuff, and it is never been an issue” (#109).

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 behavior. However, the communication methods that were used varied from one mother to another.

Talking about religious and cultural values (theme)

Mothers talked about their religious values regarding eating behavior, physical activity and drug use with their daughters. They provided them with advice and warned them about following behaviors that contradicted with Islam and or harmed their health status. Some mothers talked frequently about the Prophet Mohammad's teachings with their daughters. One mother (#102) explained:

I mean, 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. All this, like, for 24 hours, even if we try to ignore that, we can't. It is always around us.

Other participants also talked about conveying their cultural values to their daughters. For example, participant #101 was worried that her daughter might smoke because of peer pressure at school. Therefore, she questioned, communicated, and inspected as she related to her daughter.

She mentioned that she always warned her daughter about smoking and how it was not accepted for girls to smoke in her culture of origin, because it was not feminine:

I will always advise them. I will say, “It is not for money or anything. It is for your health. This is the most important, your health. And for your morals and sum’a (caring about what people will say if they know that you are smoking), not more or less. So stay away from this.” I always warn them.

Another participant (#111) described the situation when her daughter asked her why she could not have a boyfriend. She answered her that this behavior was not accepted by Islam and by her culture of origin. “This is asked by all girls, because of our culture, this and that, and that it is haram (forbidden by religion), and this and that, and they accept it.”

Six daughters mentioned that they perceived their communication with their mothers positively. They indicated that they can talk to them about everything and their mothers were good listeners, open minded and flexible. These daughters talked about how their mothers would discuss religious health values with them and how they perceived this positively because they believed that this 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, about, 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. (#206)

Topics of mother-daughter health communication (theme)

Mothers talked to their daughters about some health facts and the negative health consequences of following certain behaviors. Some talked to their daughters about how they should eat more vegetables and fruits, stop eating junk foods, and watch how much they ate 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 talked about the negative

consequences of smoking and other drug use. Participant #103, a physician, talked to her daughter about the negative health consequences of smoking:

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.

Daughters talked about health communication regarding their eating behavior and physical activity with their mothers. One participant mentioned that she would ask her mother's opinion in 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. On the other hand, some participants mentioned that they did not talk about smoking with their mothers.

Participant #202 explained:

To be honest, I feel, I don't feel like we ever covered that issue. Never. Like I know that her brother smokes and her dad, but for the most part I don't think that's been an issue in my family. Like she never discusses it with me. Maybe she discussed it with my brother, but I've never been there.

Some daughters shared health facts with their mothers more than their mothers did with them. Daughter #206 talked about how she talked to her mother about dieting and physical activity and how her mother was accepting the information:

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."

Communication methods (theme)

Immigrant Muslim mothers showed that they use a special style of communication to be able to share their health values with their daughters. They used different methods to make it easy on their daughters to understand and so accept their values.

Using explanation in health communication (subtheme)

The majority of the mothers mentioned that they used 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 say only no to behaviors that contradicted with their religious and cultural values, but they also needed to explain and answer their daughters' questions regarding these health values. "If you keep saying for everything, "haram, haram, haram, haram" to your daughter here, 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" (#104). She also 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 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. Participant #203 said, "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."

Forcing religious values on their daughters (subtheme)

A few mothers in this sample explained that when their daughters did not adopt their religious values then they would impose them on their daughters. As one participant (#108) said,

But in the meantime, 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, 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.

Similarly, some daughters described that their mothers were not open-minded. Instead, they 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. Participant #205 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.”

Only one daughter (#207) 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 everyday 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.

Flexibility with cultural values (subtheme)

Mothers showed that they were flexible with some values, especially their culture of origin values. They accepted some values from the new culture, as long as they did not contradict with Islam. One mother (#109) described being flexible regarding her daughter's interaction with boys: “For example, if she said, “ know a guy and I am talking to him,” and I know she is not gonna cross the line, she is not doing anything wrong, I would be flexible. I mean it is a relative matter.”

Some daughters described the flexibility of their mothers and how they would communicate when they had different opinions. Daughter #204 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.

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

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.”

Mothers also tried to create an environment that helped them share their values with their daughters. One mother (#107), who had problems communicating with her daughter because she was silent, mentioned, “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.” Another mother (#111) said she talks to them when they are relaxing:

I mean, in order to be able to share your values with your daughters and give them advice, you can't just sit and just tell them that. You should give them the advice in a fun environment. They will accept the advice more in fun or relaxing times, when you are relaxing give them a story or anything. Then she will ask, “Why we are doing this?” Like while watching a movie or listening to a song, then talking to her is better.

Mothers also talked about the challenges they faced while communicating with their daughters. Some talked about how the daughter's generation was different and how they asked about everything and they always wanted explanations:

The generation is different The kids have stronger characters now They want to be more responsible... The arguing, I mean, you have to convince them. I mean you have to convince them and then they may do it. So you can't just say, “Do this because.” “Why?” “Because I say so.” They will not be convinced and they may not do it and it will not work with them. (#111)

Others talked about how their daughters did not like sharing their feelings with them. They liked spending time by themselves and in their rooms, had secrets and liked sharing with friends more than with their mothers.

Maternal modeling:

Modeling health behaviors (theme)

Immigrant mothers in this study talked about how they tried to model different health behaviors for their daughters (#111): “Sometimes you don’t say things or force them, but when you *do* that, they will follow. So this is very important. It is like a model for them.” Some mothers tried to model healthy behaviors, to eat healthy, be active, and avoid smoking and drug use. Other mothers (N=3) modeled unhealthy behaviors, thus encouraging their daughters to follow the same behaviors.

Modeling eating behavior

The majority of the mothers tried to prepare healthy meals for their families. They tried to eat vegetables and fruits, avoided eating fast foods and or at restaurants, and also encouraged their daughters to follow the same behavior. Ten daughters had positive perception of their mothers modeling healthy behaviors. They talked about how their mothers were their models when it comes to eating behavior:

She focused a lot on eating healthy food and stuff, and like I, like I don’t remember last time I’ve seen her eating sweets and stuff. She tries to avoid eating sweets and stuff, and high fat foods. She likes to eat fruits and veggies. She will pick healthy foods and cook healthy meals, Yeah, I can feel she is my model, like when it comes to health wise.
(#209)

Physical activity

Some of the mothers tried to be active and encouraged their daughters to be active. Those mothers who were walking often took their daughters with them. Participant #101 mentioned,

“In most cases I will go with her. Sometimes the other daughters will come with us. We will walk.” Other mothers talked about how they took their daughters with them to the gym. This included modeling along with the earlier theme of spending quality time together.

Modeling drug use

Three mothers modeled using argile or shisha (water pipes) and encouraged their daughters to follow this behavior because it was part of their culture or origin. “I sometimes argile (use a water pipe) with my daughter [laugh]. It is in style. I want to make her busy” (#104).

Five mothers mentioned that they thought their daughters were accepting of them as their role models of different health behaviors. Mother #109 mentioned: “Yeah, I think yes, they always tell me, ‘You are our model, Mama.’” Four mothers felt that they were not their daughter’s models when it comes to health behavior

She makes many comments on my weight. She always tells me, “Get on a diet. Get on a diet.” And I am just ignoring. Ehh. “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. (#107)

One mother mentioned that although her daughter was not accepting her as a role model now, later she would accept her. “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]” (#110).

Ten daughters described positive perceptions of their mothers modeling health behaviors. “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” (#210). Participant #209 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 behaviors, such as having shisha together or eating unhealthy foods.

On the other hand, three daughters indicated that they would not consider their mothers as their models regarding their health behavior because they were exhibiting unhealthy behaviors. Two of them mentioned that their mothers were not as active as they should be. The other daughter mentioned 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” (#207).

Research Question 6: How do the daughters’ perceptions of their mothers’ health values (shaped by the 3 factors) influence the daughters’ health behaviors?

Seven daughters felt that they were following healthy behaviors regarding eating behavior, physical activity, and drug use. These participants did not eat pork, tried to eat vegetables and fruits, enjoyed the Arabic traditional meals cooked by their mothers which they considered healthy meals, avoided eating junk foods, and eating at restaurants.

I personally hate like the fast food and stuff. It doesn’t appeal to me what soever. I try to keep away from that. I don’t eat school lunches... because my mom cooks Arabi food all the time. I love Arabi foods. Even like when we go out, I would rather, I prefer my mom’s food over restaurants’ foods. (#201)

These daughters tried to be active and exercise regularly; they attended gym clubs, ran, walked, did track, and or swam. Additionally, they did not smoke cigarettes and they had a negative perception of smoking behavior.

The other four participants mentioned that they were working on improving their health behavior by trying to eat healthy and be active. They ate junk foods, they did not exercise regularly, and three of them were doing argile (water pipes) with their mothers. These healthy and unhealthy behaviors were shaped by the three factors: religion, mother's culture of origin, and the dominant new culture.

Influence of mother's religious values on adolescent daughter's health behavior
(theme)

All the participants showed that their health behaviors were shaped by their mothers' religious values. Regarding eating behavior, all of them mentioned that they did not eat pork, ham nor gelatin and that they would always read the ingredients for whatever products they bought. Only one participant mentioned that she also followed the religious values regarding the food portion size: "I follow no pork, no alcohol. I follow 100%. But, like, even in moderation and everything, I follow that too" (#209).

Religious values also shaped their physical activity. Participants mentioned that when they did track and or swam, they would dress modestly. "I am also practicing track and I will be with boys and girls and I will wear something under my shorts. You know, all will be covered" (#202). Participants who practiced swimming talked about how it was a challenge for them to swim and also keep their religious values.

We swim in undershirts and then t-shirts. It is kind of like a lot of clothes, but we are used to it. And then sometimes like we go and we sleep over in our friends' houses or something and they usually have neighborhood's pools, and they were like closed at night. But we just like sneak in because nobody is there, and we just swim like in regular clothes like shorts and like a tank top. (#201)

Regarding drug use, all the participants mentioned they never tried alcohol and that was a "red line" for them. In addition, nine participants were nonsmokers, partly because of their

religious values. “Yeah. I personally think smoking is like one of the most disgusting things...I don’t do that it is not part of my religion. It is not part of my, you know, how I grew up. I am not interested in it like at all” (#201).

The daughters showed positive perception of the influence of Islamic values on their health behaviors. Participant #206 talked about this: “In Islam it tells us, like, um, well it tells us, encourages us to take care of ourselves, and to exercise, eat healthy, not to smoke, not drink, not eat pork. And all this is good for us, not because we should do it, but because it is good for us.”
Influence of mother’s culture of origin values on adolescent daughter’s health behavior (theme)

Participants showed that their health behavior was also shaped by their mothers’ culture of origin values, though it seemed to be the least influencing factor. They liked eating the Arabic traditional meals their mothers cooked for the family and they thought they were healthy. For physical activity they showed that they might quit the sports that were not accepted by their mothers’ cultural values.

Sometimes, when it comes to school activities though, she is kind of like, backs off. She will be like, “Oh, what do you need those for?” Like, for example, I did track for a year, and, I don’t know, I could say that’s the most they provided. Like they didn’t, they didn’t stop me from doing this, but they were like, “Whatever, you can do it.” Um, but yeah, then I didn’t really like that, so I kind of backed down. (#201)

For some daughters, their drug use values were shaped by the old culture of their mothers. Three participants were using argile with their mothers. ”We will have shisha together, like most of the time, like it is part of the culture. It is part of the Arab culture. So it is kind of one of those things that are accepted by the culture” (#209).

Influence of the United States Acculturation on the adolescent daughter’s health behavior (theme)

American Muslim adolescent daughters also showed that they were influenced by the acculturation in the United States. Some of them showed that they were eating fast foods and or eating at restaurants. This was a habit for the family of daughter #203 whose mother was a physician: “Every weekend we sort of do that. Most of the time we go to have breakfast.”

All the daughters identified that their physical activity was shaped by the new culture. They loved to be active, walk, run, do sports, go to the gym, do track and swim. The majority believed that the American culture educated them and increased their awareness about healthy behaviors. “I think I am influenced by the American culture, because they care a lot about physical activity and healthy foods. It is not that they do it, but they do a lot of awareness. They will tell you what’s right and wrong” (#206). One participant (# 109) mentioned that she swam in mixed pools and wore a swimming suit: “I mean, like I was always able to wear everything else, and to be in the pool and I can wear swimming suits, and I can go to mixed pools and stuff and it is never been an issue.” Regarding drug use, the majority mentioned that the dominant new culture played a big role in educating them about the negative consequences regarding drug use, especially smoking behavior.

Importance of daughters’ perceptions of mothers’ values and behavior (theme)

How the daughters perceived their mothers’ health values was shaped by the three factors: religion, culture of origin, and acculturation in the United States. Of the eleven adolescent girls I interviewed, only five participants mentioned that their mother’s health values were shaped by the three factors: religion, culture of origin, and the acculturation in the United States. Four daughters identified that their mothers’ values were mainly shaped by two factors; three of them emphasized religion and culture of origin and one participant said that the two

factors were religion and the American culture. Finally, two girls said that their mothers' health values were largely shaped by their cultures of origin.

Positive perception of the mothers' health values

The daughters who felt that there were three factors influencing their mothers' health values (202, 208, 209, 210, and 211) perceived these values positively and felt that their mothers had healthy values and they were encouraging them to follow healthy behaviors. One participant (#208), a freshman in college, described how these three factors played together regarding her dating behavior:

I think it is kind of a mix of all three. There is a lot of, um, she is very open to new ideas that I got just being an American teenager. Um, but there are also other things. Like I am not allowed to date. and that's kind of set rules that are both cultural and religious. Um, so she does have a mix of different values.

These daughters perceived their mothers' religious health values and the influence of the new culture on their mothers' health values positively. Some participants talked about how their mothers' health awareness improved in the new culture and how they knew more about the negative consequences of following unhealthy behaviors than when they were back in the Middle East.

I think it is just because she sees what happens to people, you know, the obesity, and she just doesn't want us to be like that. And she wants us to be healthy, and she knows a lot more about that now than she used to when she was living in the Middle East. She comes here and she knows more now about that. (#210)

These girls might have value conflicts with their mothers, which they said are more about the cultural values, not the religious ones. As a result, these daughters were more likely to follow healthy behaviors, even when their mothers were not following healthy behaviors, because they would have the freedom to make healthy choices in the new U.S., even healthier than their mothers' behaviors.

For example, participant #202 felt that her mother's health values were shaped by the three factors. She perceived them positively and felt they were healthy and felt that her mother was encouraging (by following the different maternal practices) her to follow healthy behaviors. Although the mother was not active herself, the daughter followed healthy behaviors; she was eating healthy most of the time (more fruits and vegetables, no soda, no chips, avoid eating at restaurants or fast foods), very active (did track, tennis, swim, run, and walk) and did not smoke. So the daughter agreed with her mother in her eating behavior and drug use, even though she was more active than her mother. She said she was influenced by the new culture regarding the freedom in making healthy choices to stay active adding to this that her mother was open to these new values.

Only one daughter (#205) felt that her mother's health values were shaped mainly by religion and the American culture. This daughter showed positive perception of her mother's health values and mentioned that generally she did not have conflict with her mother. As a result, the daughter followed healthy behavior; she attended the gym, she tried to eat healthy and watched her body weight, and she did not smoke.

Negative perception of the mothers' health values

Three daughters (201, 203, and 206) mentioned that their mothers' health values were shaped mainly by religion and culture of origin. These participants perceived their mothers' religious values positively. Participant #206 explained how religion asked Muslims to stay away from smoking and eating pork for their benefit:

Because my religion is right, it only tells us what's best for us, like no smoking. Why? Because it is harmful for our bodies, and we respect our body. We care about it. Not because they don't want us to have fun or because they don't want us to enjoy our time. It is just because for our own good. They will ask us to do things and follow behaviors that are good for us.

Well, because there is a reason for it, because, you know, like a couple years back they came up with the swine flu or something. And that's like, thanks God, like. Allah said, "Don't eat pigs." And this flu came out from what? The pigs, and we don't eat pigs. So we Muslims don't have this disease because we don't eat pigs. Thanks God.

These daughters perceived their mothers' values regarding eating behavior and drug use positively, but they perceived their mothers' values regarding physical activity negatively. As a result, with the influence of the new culture on them they would try to be more active than their mothers, but then they might have value conflict with their mothers and quit the activity. One participant talked about how she liked doing track and riding bikes, but her mother was not supportive because she thought that there was no need to practice these sports. The daughter (#201) explained, "They're, my parents, gonna stick [to their ideas] for some reasons. And I think, "I love biking and stuff." For some reason they don't. In their culture, Arab culture, it is not seen as something positive, you know. I don't understand that, you know." Another participant (# 106) showed negative perception of the women's health values regarding physical activity in her mother's country of origin (Syria). This was her answer when I asked her if she thought her mother was more active in the old culture than in the new culture: . "I don't think so, I mean playing around the house probably {laugh}."

Finally, two participants identified that their mother's culture of origin was the main influencing factor to their mothers' health values. These daughters showed different perceptions of the old culture's values. One of them (#204) perceived these values positively and mentioned that her mother was following healthy behavior, even though the mother was using argile and was not active. As a result, the daughter's health behavior was influenced mainly by her mother's religious and culture of origin health values, because she was not active and she was using argile.

The other daughter (#207) showed that she had negative perception of her mother's health values regarding eating behavior, physical activity, and smoking. She perceived her mother health values and behaviors as unhealthy and she was always encouraging her to follow healthier one as she explained:

She smokes to make her feel better She eats to make her feel better...That's like her family. Her old family, they eat a lot. They're all overweight. They all smoke. So I am pretty sure she got influenced by them as well...Over there she is probably like always stuck with her family, so she doesn't really know. Or may \be when she was younger she didn't know that smoking will really hurt that much and will affect her health later.

This daughter tried to choose behaviors, which were "different" from her mother's behavior, because she thought they were unhealthy. She tried to eat healthy, she tried to be active by walking, and she was not smoking.

This chapter gives thick description of the data from both mothers and their daughters in this study. The research questions examining the influence of religion, culture of origin, acculturation, mother-daughter relationships, and daughters' perception on the daughters' health behavior in the United States were addressed and major themes, subthemes and the textural description were provided. Direct quotes from the participants (both mothers and daughters) were included to enhance the validity of the themes and subthemes.

The next chapter will discuss the major themes and synthesize a structural description of the findings. A theoretical model explaining how addressing the different contexts: mother-daughter relationships, mother's religious and cultural values, and the influence of acculturation would explain the adolescent daughter health behavior living in a Muslim community in the United States will be developed. The model will explain how the daughters' perceptions of these values and maternal relationships are an important factor in shaping the daughters' health behaviors. In addition, the broader implications for the findings and the model will be addressed.

Chapter 5 - Discussion

In this chapter, I discuss how the results of this study relate to the existing literature and the evidence in similar research in order to enhance the substantive significance of the findings. Patton (2002) named this as confirmatory significance, which he defined as the method to see to what degree the findings are consistent and may be supported by previous knowledge. Next, I explore how the three factors religion, culture of origin, and acculturation together shaped the mothers' health values and mother-daughter relationships and as consequence how they can shape adolescent daughters' health behavior. I also briefly discuss and interpret the findings by applying the ecological theory. Furthermore, a theoretical model is presented with implications for family life educators and health educators. Finally, I addressed the strengths and limitations, as well as the suggestions for future research.

How does religion influence immigrant Muslim mothers' health values?

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 – religious practices and beliefs – greatly shaped their health values regarding eating, physical

activity, and drug use. These mothers indicated that whether they wore a Hijab or not, whether they prayed at home or prayed at the mosque, they were following the religious beliefs from the Qur'an. 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 behavior, then the mother's culture of origin shaped her health values. For example, because there is no explicit law about smoking, the mothers varied in explaining why they did not smoke (and one mother did smoke). Their reasoning seemed to be based on how they interpreted the Qur'an in their culture of origin and the forbidden behaviors in their countries of origin. Because they were from different countries in the Middle East (Egypt, Lebanon, Iraq, Kuwait, Jordan, Syria, and Palestine), these participants held different interpretations of the religious laws in Qur'an regarding smoking.

How does culture of origin influence immigrant Muslim mothers' 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 back home 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.

The Health Belief Model could help explain why these mothers chose these healthy and unhealthy values. According to the perceived benefits concept, immigrant Muslim mothers

perceived their traditional meals from back home as healthy meals and that these meals helped them stay healthy and safe from different health issues, especially obesity. As a result, they cooked these meals for their families. On the other hand, the perceived barriers concept in the Health Belief Model can explain why they chose some unhealthy values. Mothers who walked to stay active and could not go to the gym or swim, chose this activity because it was allowed and accepted in their countries of origin. They chose to practice what was common in the old culture. Some of the mothers did not smoke because it was not accepted for women to smoke in their cultures of origin; it was considered unfeminine. However, others used shisha because there were no cultural barriers against women using it in their country of origin. In fact, a few of the mothers and daughters indicated that they used the water pipes to preserve a tradition of their original culture.

An interesting theme under the country or origin factor was that some mothers talked about how it was hard to separate the influence of religion from culture of origin on their health values. This was clear when they explained why they were not smokers. Some mothers indicated that they did not smoke because it was forbidden by religion and this was also how their parents raised them back home, and because it was not accepted by culture of origin for women and girls to smoke. These women described both religion and culture of origin in their answers. They saw them as intertwined. It was also clear when they talked about swimming as an activity in general or about swimming in mixed pools specifically. Mothers in this study avoided talking about swimming as an activity because of both the religious values regarding the modest dressing and the cultural values that this activity was not common for women in the old culture.

Various countries from the Middle East have different cultures and so there are diverse cultural values regarding women behaviors. 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.

The participants in this study were originally from Middle Eastern countries that ranged from liberal to conservative. Not surprisingly, the 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.

However, these mothers are no longer living in their countries of origin. They are immigrants in the United States. In order to understand their health values in the new culture, acculturation also must be examined.

How does acculturation in the U.S. influence immigrant Muslim mothers' health values?

Contrary to what some researchers found about the challenges Muslim families might face following religious values in the United States (e.g., Ross-Sheriff, Tirmazi, & Walsh, 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. All immigrant Muslim mothers in this sample mentioned that they did not change their religious values in the new culture since these

values were “red lines” for them and for their families. Participants talked about how there was respect and understanding for their religious values from Americans in the new culture.

Previous research (e.g, Guilamo-Ramos, Jaccard, Pena, and Goldberg, 2005) addressed time as a factor that might influence the acculturation process. It is expected that over time immigrants make adjustments and changes in their values and become more acculturated. However, length of residency in the new culture was not evident in the reports of mothers in this sample indicating that they changed their religious values; whatever their length of residency in the United States, these mothers said that they would never leave out their religious values. Additionally, a few talked about how they were still keeping their culture of origin health values because they felt they were good for them and their families.

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 behaviors. For example, some mothers did not prepare the three meals for their families and they ate more in restaurants than what they used to in their countries or origin. This could be explained by the fact that these mothers had jobs, which made them stay out of the home for long hours, so they did not have the time and energy to prepare three meals each day for the family.

Sussner, Lindsay, Greaney, and Peterson (2008) found that immigrant Latino mothers in the United States perceived the impact of acculturation on their eating behavior and physical activity negatively. They felt that they were following healthier behaviors 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 behaviors 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.

Religion, culture of origin, and acculturation together shaped immigrant Muslim mothers' health values. What about the practices used to share their health values with their American Muslim adolescent daughters in the United States? The next section will address the mother-daughter relationships, which include relationship quality, availability, monitoring, communication, and behavior modeling.

What is the general nature/quality of immigrant Muslim mother-daughter relationships?

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, Tirmazi, & Walsh, 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 back home. 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 “overprotection” of religious and cultural values by Muslim immigrants in the Unites 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 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. However, in the end, it was also their responsibility as immigrant Muslim Middle Eastern mothers to teach their daughters about Islam, share their religious and cultural values with them, and also let them be active members in the new culture. So these mothers were trying to help their daughters have a “bicultural identity,” because they thought that this was necessary for healthy development.

Mothers who have positive mother-daughter relationships are able to share their values with their daughters (Miller, 2002). 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. This matches what I found in this study. Immigrant Muslim mothers in this study tried to have a positive mother-daughter relationship; they tried to be close, good listeners, open minded, flexible and supportive. The majority were available by having family meals together, sitting together as a family in the evenings, hanging out together, shopping together, or being available anytime their daughters wanted them. These mothers felt that by being close and available they would be able to share their religious values with their daughters.

Immigrant Muslim mothers in the context of this positive relationship followed other maternal practices to be able to share their health values with their daughters. They followed health-related maternal practices which include: monitoring, health communication, and health behavior modeling.

What are immigrant Muslim mothers' health-related mothering practices?

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 theaters, 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 behaviors 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 expectation because of their responsibility in front of their extended families back home and the fear of being unable to raise Arab Muslim daughters.

The age of the daughter also could be considered a factor that might influence the permissiveness of the mother’s values. The older the daughter, the more permissive the mother’s values were. Mothers with college students were more permissive than those with younger daughters in monitoring their daughter’s health behaviors. These mothers thought that the older their daughters were, the more responsible they could be to make healthy choices and not to cross the “red lines.” Mothers of college daughters showed that they and their daughters already reached the level of understanding of their duties and rights. This also could be because these mothers had more liberal values than others in parenting their children; they were from Lebanon and Egypt.

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 (Miller, 1998). 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 behaviors 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 behaviors with their daughters. They provided them with advice and warned them about following behaviors that contradicted with Islam or harmed their health.

Ross-Sheriff et al. (2007) reported that immigrant South Asian mothers tried to use special communication styles to share their values with their daughters; they had open communication and they were good listeners. The majority of the mothers in my study mentioned that to share their religious values with their daughters they used explanation to help them understand and accept these values, and if they were not convinced they would impose these values on their daughters. To be sure that their daughters would follow these religious values, mothers described these religious values as “red lines” and boundaries that should not be crossed. But they were flexible with other values, such as their culture of origin values, and they were accepting of some values from the new culture, if they did not contradict with Islam.

Mother-daughter communication was challenging and sometimes problematic for the mothers and daughters in this study. Although the mothers tried different methods during the communication process and they tried to create the environment to convince their daughters, sometimes they ended up forcing some values on them. As a result, there would be conflict between them. But, as the majority of both mothers and daughters mentioned, this conflict was about the cultural values more than the religious ones. That was the reason these mothers ended up giving up some of their cultural values in the new culture.

Health behavior modeling was another maternal factor that was examined in this study. Previous researchers reported that mothers could share their healthy or unhealthy values by modeling the health behavior for their children (Brook, Rubenstone, Zhang, & Brook, 2012; Fitzgibbon, Stolley, Avellone, Sugerman, & Chaves, 1996; Stolley & Fitzgibbon, 1997). Immigrant Muslim mothers modeled various health behaviors. Some tried to be role models for healthy behaviors; 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 were modeling unhealthy behaviors by eating unhealthy, not being active, and smoking.

How would the daughter perceive these unhealthy values for her mother? Would she still perceive them positively and so they would shape her health behavior? The next section will address the daughters' perception as a factor to understand how American Muslim adolescent daughters could be influenced by their mothers' health values.

How do the daughters' perceptions of their mothers' health values (shaped by the 3 factors) influence the daughters' health behaviors?

Daughters' perceptions of their mothers' practices have been underexamined in previous research. Therefore, this study included an examination of how the daughters perceived their mothers' health values and the practices used to share these values and how these perceptions shaped the daughters' health behaviors.

Ross-Sheriff and Husain (2004) mentioned that South Asian Muslim immigrants to the United States were living in a complex culture which is a combination of the Islamic teachings, the culture of national origin, and the dominant American culture. Then they added as consequence their children pulled their values from: Islamic teachings, culture of origin, American society, and peers and mass media. The findings from this study revealed that health

behavior of Arab American Muslim adolescent daughters in the Midwest of the United States was shaped by the same factors: religion, mother's culture of origin, and acculturation.

American Muslim adolescent daughters in this study indicated that their health behaviors were shaped by their mothers' religious values: they did not eat pork, they dressed modestly for swimming and the track, and they did not drink alcohol. In addition, they recognized that they were influenced by their mothers' culture of origin values: they ate the Arabic traditional meals their mothers cooked for the family, they quit the sports that were not accepted by their mothers, and some used argile. Finally, the American Muslim adolescent daughters in this study showed that they were greatly influenced by the acculturation factor. The majority agreed that the new culture increased their health awareness and encouraged them to eat healthy foods. All the participants showed that their physical activity was shaped by the new culture; they loved to be active, walk, run, do sports, go to the gym, do track and swim. For drug use, the majority mentioned that the dominant new culture, especially the schools, played a big role in educating them about the negative consequences regarding smoking.

In this study, American Muslim daughters who perceived their relationships with their mothers positively explained that they were influenced by their mothers' health values and, as a result, shaped their health behaviors. Applying Ecological theory helps explain this finding. The microsystem includes the health behavior of the American Muslim adolescent daughter by addressing her relationship with her mother as the context. It is expected that the more positive and healthy the relationships between the mother and her daughter, the more likely the daughter will be influenced by her mother's health values. As a result, they will shape her health behavior.

Immigrant Muslim mothers were close to their daughters, available, monitored their daughters' behavior, communicated about their values with their daughters, and modeled

different health behaviors. The daughters who felt that their mothers' were supportive, flexible, open minded, and good listeners, perceived their mothers' health values positively which shaped their health behavior. However, the daughters who felt that their mothers were putting their opinion in whatever they did, imposing things on them, "old fashioned", and not supportive. These daughters perceived their mothers' health values negatively and they did not shape their health behavior.

The exosystem in the Ecological theory focuses on the impact of external settings that have no direct effect on the daughter. The exosystem includes the health behavior of the American Muslim adolescent daughters by addressing the mothers' religious and cultural values as the second context. Islam and culture of origin shaped immigrant Muslim mothers' health values in the United States. All the American Muslim adolescent daughters in this study perceived the religious values of the mother positively as a result they shaped their health behaviors. On the other hand, the daughters perceived some of the culture of origin values negatively and as consequence they did not shape their health behaviors.

Finally, the macrosystem explains another context influencing this relationship; acculturation and the influence of the new culture. Addressing this context helps explain the influence of the acculturation process on immigrant Muslim mothers' health values in the United States, the adjustments and or changes they made on their religious and cultural values and as a consequence how this influenced their daughters' health behavior. The majority of the mothers showed that they were more religious in the United States because they knew the "right Islam" here. Others explained that they were forced to leave out their culture of origin values and accept some values from the new dominant culture that did not contradict with Islam to survive with their daughters in the new culture. Daughters who felt that their mothers' health values were

shaped by the acculturation factor, perceived these health values positively and so shaped their health behavior. On the contrary, the daughters who felt that their mothers' health values were not influenced by the new culture, perceived these values negatively and did not shape their health behavior.

Theoretical Model

I developed a theoretical model (Figure. 1) from the findings that helped explain how immigrant Muslim mothers can influence their American Muslim adolescent daughters' health behavior in the new dominant culture. Or in other words it helped explain the different ecologies and factors shaping the daughter's health behavior.

The model illustrates that in order to have a better understanding of the factors influencing the daughter's health behavior within a Muslim community in the United States, it would be beneficial to address the maternal relationships and practices followed by immigrant Muslim mothers in the community as a context. Mothers in this study showed that they were trying to have positive relationships with their daughters by being close, supportive, and available. In addition, they followed other health-related parenting practices such as monitoring their daughter's health behavior, handling health communication with different communication methods, and modeling different health behaviors.

This theoretical model shows that these maternal practices can be explained in more depth by addressing the mother's health values. The findings from the analysis revealed that immigrant Muslim mothers' health values in the United States were shaped by religion as beliefs and practices (+1.0) and culture of origin (+2.0) with varying degrees for both of them. Mothers in this study showed variety in how they were influenced by religion. Some mothers were conscious about the religious health beliefs and ideals, while others were not. Additively the

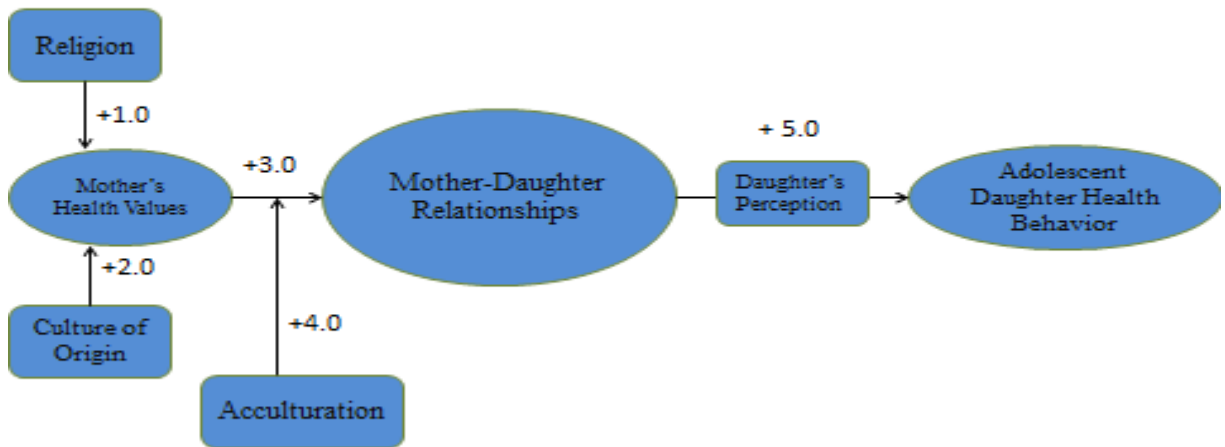
mothers showed variety in how they were influenced by their culture of origin; their values ranged from conservative to liberal.

However these religious and cultural values were influenced by the acculturation in the dominant new culture (+4.0). So the model addresses another context and assures that we can not understand immigrant Muslim mothers' health values in isolation from the influence of the dominant new culture. Mothers in the current study showed variety in how they were influenced by the acculturation factor. The majority of the mothers showed that they were more religious in the United States because they knew the "right Islam" here. Others explained that they were forced to leave out their culture of origin values and accept some values from the new dominant culture that did not contradict with Islam to survive with their daughters in the new culture.

The model explains that adolescent daughters will be influenced by their mothers' health values; yet, it depends on how they perceive these values (+5.0) shaped by the three factors. So that daughters who perceived their mothers' health values positively, were more likely to be influenced by these values than daughters who perceived them negatively and as a result they would shape their health behavior. In this study the daughters mainly perceived their mothers religious and acculturated health values positively and so their health behavior was shaped by Islam and the new culture. On the other hand the daughters perceived some of their mother's culture of origin values negatively and thus the least influencing factor on their health behavior was their mothers' culture of origin.

Figure 5.1

A Theoretical Model of Immigrant Muslim Mothers' and their American Muslim Adolescent Daughters' Perceptions of the Mothers' values, Mother-Daughter Relationships and their Influence on Daughter's Health Behavior



Strengths and Limitations of the Study

This qualitative research study examined how mother-daughter relationships within a Muslim community could influence the daughter's health behavior in the United States. In order to examine these maternal practices in depth and understand how they can influence the daughters' health behavior, the mothers' cultural and religious values were addressed as a context. In addition, the acculturation factor was addressed as another context to understand the

influence of the new culture on the mothers' health values and as a consequence on the daughter's health behavior. Addressing the three context enrich this research study and the findings.

The second strength in this study is the thick description of the phenomenon that I acquired from interviewing both immigrant Muslim mothers and their American Muslim adolescent daughters. Being able to interview both mothers and their daughters enhanced the accuracy of the findings. More analyses can be conducted on the data for future research.

The third strength is the theoretical model I developed. The model provides an understanding of how the different environments surrounding American Muslim adolescent daughters in the United States can shape their health and social behavior.

However, this 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 I was looking 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 and the model to other non-Arab Muslim communities. Third, recruiting the daughters only after the mother talked to them about participation in the study might have resulted in some daughters feeling forced to participate and to give religious and socially desirable answers.

Implications for Research

The findings and the theoretical model address some gaps in the literature regarding immigrant Muslim mothers' health values, mother-daughter relationships and maternal practices within a Muslim community in the United States, the health behavior of American Muslim adolescent daughters and the influence of the different ecologies surrounding these relationships and this behavior: Religion (Islam), culture of origin, and acculturation. Findings and conclusions of my study should be treated as hypotheses for future testing rather than as definitive.

Future research should focus on the influence of the school environment – public or Islamic – the influence of peer pressure and friendship, and the influence of media and technology on American Muslim adolescent daughters' health behavior. Other research questions I am interested in examining include:

- Why do immigrant Muslim mothers keep defining country of origin as a static environment?
- How different health issues influenced immigrant Muslim mothers' health values and behavior?
- How does visiting country of origin influence American Muslim adolescent daughters' behaviors, health and social?
- Experimentation for American Muslim adolescent daughters and healthy development.

Implications for Practice

Findings from this study can be helpful for family life educators, family therapists, 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 life education, knowledge about these maternal factors can be used to educate parents and enhance the skills of mothers so they can help their daughters engage in

healthy behaviors. 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 behavior.

For example, in the case of mother-child communication, the findings from this study can be helpful in educating mothers about the communication methods they can use when having discussions with their adolescent daughters. Immigrant Muslim mothers talked about how they give explanation and answered their daughters' questions. They also showed how they were good listeners to their daughters and were being flexible. Regarding the mother-daughter relationship, the mothers showed how they could be close to their daughters by being available and involved in their lives and activities.

Second, in the public health area, the findings of this research study 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 programs, 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 increasingly rooted in the organization and expectations of everyday life (Resnick, Harris, & Blum, 1993). 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 (physical, self-definitional and social) changes of adolescence.

Third, the findings and the model help explain the diversity among immigrant Muslim mother's health values, and thus their maternal relationships and practices. This helps

professionals understand that they can not 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

I believe 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 behaviors within Muslim communities in the United States and in other Western cultures.

The findings and the theoretical model will help explain how these maternal factors can work together to shape the adolescent daughter's health behavior. 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.

References

- Abu Dawud, S. (2000). *Sunan Abu Dawud*. Basic Stock Line. Translated by Ahamd Hasan.
- Abudi, D. (2011). *Mothers and Daughters in Arab Women's Literature: The family Frontier*. Leiden, the Netherlands: Koninklijke Brill NV.
- Airhihenbuwa, C. O., Kumanyika, S., Agrus, T. D., & Lowe, A. (1995). Perceptions and beliefs about exercise, rest, and health, among African Americans. *American Journal of Health Promotion*, 9(6), 426-429.
- Al- Bukhari, M. I. (1997). *Sahih Al –Bukhari*. Riyadh: Al- Saadawi.
- Al jazairi, A. (1976). *Mihaj Al-Muslim*. Damascus: Dar Al-Fikre.
- Al-Mateen, C. S., & Afzal, A. (2004). The Muslim child, adolescent, and family. *Child and Adolescent Psychiatric Clinics National American*, 13, 183-200.
- Al-Qurtubi, M. I. (1967). *Al-Jami Li Ahkam Al-Quran*. Cairo: Dar Al-Katib Al-Arabi.
- Arab American Institute. (2007). *Demographics*. Retrieved August 16, 2007 from http://www.aaisua.org/arab_americans/22/demographics.
- At-Tabarani, S, A. (2008). *Al-Mujam al-Kabir*. Riyadh: Juraysi.
- Bakalian, A., & Bozorgmehr, M. (2009). *Backlash 9/11: Middle Eastern and Muslim American Respond*. Berkeley: University of California Press.
- Baker, C. W., Whisman, M. A., & Brownell, K. D. (2000). Studying Intergenerational Transmission of eating attitudes and behaviors: Methodological and conceptual questions. *American Psychological Association*, 19(4), 376-381.
- Bakhtiar, L. (2007). Medicine and healing in traditional Islam. In V., Cornell (Ed.), *Voice of Islam*, V 4 (pp. 153-154). Westport, CT: Praeger Publishers.

- Barber, B. K. (1994). Cultural, family, and personal contexts of parent-adolescent conflict. *Journal of Marriage and the Family*, 56, 375-386.
- Basit, T. (1997). *Eastern Values; Western Milieu: Identities and Aspirations of Adolescent British Muslim Girls*. Aldershot: Ashgate Press.
- Block, J., Block, J. H., & Keyes, S. (1988). Longitudinally foretelling drug usage in adolescence: Early childhood personality and environmental precursors. *Child Development*, 59, 336-355.
- Blokland, E. A. W., Hale III, W. W., Meeus, W., & Engels, R. C. M. (2007). Parental support and control and early adolescent smoking: A longitudinal study. *Substance Use and Misuse*, 42, 2223-2232.
- Bourdeaudhuij, I., & Oost, P. (1998). Family members' influence on decision making about food: Differences in perception and relationship with healthy eating. *American Journal of Health Promotion*, 13(2), 73-81.
- Branstetter, S. A., Furman, W., & Cottrell, L. (2009). The influence of representations of attachment, maternal-adolescent relationship quality, and maternal monitoring on adolescent substance use: A 2-year longitudinal examination. *Child Development*, 8(5), 1448-1462.
- Bronfenbrenner, U. (2005). *Making human beings humans: Bioecological perspectives on human development*. Thousand Oaks, CA: Sage.
- Brook, J. S., Rubenstone, E., Zhang, C., & Brook, D. W. (2012). Maternal predictors of comorbid trajectories of cigarette smoking and marijuana use from early adolescence to adulthood. *Addictive Behaviors*, 37, 139-143.
- Brooks, J. (2004). *The Process of Parenting*. Boston: McGraw-Hill.

- Brown, J. D., Engle, K. L., Pardun, C. J., Guo, G., Kenneavy, K., & Jackson, C. (2006). Sexy media matter: Exposure to sexual content in music, movies, television, and magazines predicts Black and White adolescents' sexual behavior. *Pediatrics, 117* (4), 1018-1027.
- Buhrmester, D. (1996). Need fulfillment, interpersonal competence, and the developmental contexts of early adolescent friendship. In W. Bukowski, A., Newcomb, & W. Hartup (Eds.), *The company they keep* (pp. 158-185). New York: Cambridge University Press.
- Bynum, M. S. (2007). African American mother-daughter communication about sex and daughters' sexual behavior: Does college racial composition make a difference? *Cultural Diversity and Ethnic Minority Psychology, 13*(2), 151-160.
- Cantor, J., Mares, M. L., & Hyde, J. S. (2003). Autobiographical memories of exposure to sexual media content. *Media Psychology, 5*(1), 1-31.
- Centers for Disease Control and Prevention. (2004). Youth risk behavior surveillance – United States, 2003. *Morbidity and Mortality Weekly report, 53* (SS2), 1-100.
- Chilman, C. S. (1990). Promoting Healthy adolescent sexuality. *Family Relations, 39*(2), 123-131.
- Chodorow, N. (1978). *The reproductive of mothering*. Berkeley: University of California Press.
- Collins, W. A., & Russell, G. (1991). Mother-child and father-child relationships in middle adolescence: A developmental analysis. *Developmental Review, 11*, 99-136.
- Coombs, R. H., & Landsverk, J. (1988). Parenting styles and substance use during childhood and adolescence. *Journal of Marriage and the Family, 50*, 473-482.
- Corbin, J., & Strauss, A. (1990). *Basics of qualitative research* (3rd edition). Thousand Oaks, CA: Sage.

- Corbin, J., & Strauss, A. (2008). *Basics of qualitative research* (3rd edition). Thousand Oaks, CA: Sage.
- Council on American-Islamic Relations. (2003). *About Islam and American Muslims*. Retrieved May 17, 2003 from: <http://www.cair-net.org/asp/aboutislam.asp>.
- Crosnoe, R., Erickson, K. G., & Dornbusch, S. M. (2002). Protective functions of family relationships and school factors on the deviant behavior of adolescent boys and girls: Reducing the impact of risky friendships. *Youth and Society, 33*, 515-544.
- Day, K., & Cohen, U. (2000). The role of culture in designing environments for people with dementia. *Environment and Behavior, 32*, 361-399.
- Dilorio, C., Hodkenberiy-Eaton, M., Maibach, E., Rivero, T., & Miller, K. (1996). The content of African American mothers' discussions with their adolescents about sex. *Journal of Family Nursing, 2*(4), 365-382.
- Dilorio, C., Resnicow, K., Dudley, W. N., Thomas, S., Wang, D. T., & Marter, D. F. V., et al. (2000). Social cognitive factors associated with mother-adolescent communication about sex. *Journal of Health Communication, 5*, 41-51.
- Dowda, M., Pate, R. R., Felton, G. M., Saunders, R., Ward, D. S., Dishman, R. K., et al. (2004). Physical activities and sedentary pursuits in African American and Caucasian girls. *Research Quarterly for Exercise and Sport, 75*, 352-360.
- Dutra, R., Miller, K. S., & Forehand, R. (1999). The process and content of sexual communication with adolescents in two parent families: Associations with sexual risk-taking behavior. *AIDS & Behavior, 3*, 59-66.
- Edmunds, H., & Hill, A. J. (1999). Dieting and the family context of eating young adolescent children. *International Journal of Eating Disorders, 25*, 435-440.

- Ekram & Beshir, M. R. (2007). *Muslim teens- A practical parenting guide: Today's worry, tomorrow's hope* (3rd ed.). Beltsville, MD : Amana Publication.
- Fitzgibbon, M. L., Stolley, M. R., Avellone, M. E., Sugerman, S., & Chavez, N. (1996). Involving parents in cancer risk reduction: A program for Hispanic American families. *Health Psychology, 15*, 413-422.
- Flynn, K. J., & Fitzgibbon, M. (1998). Body images and obesity risk among black females: A review of the literature. *Annals of Behavioral Medicine, 20*(1), 13-24.
- Gilligan, C. (1982). *In a different voice: Psychological Theory and Women's Development*. Cambridge, MA: Harvard University Press.
- Gilligan, C., Rogers, A., & Tblman, D. (1991). Women, girls and psychotherapy: Reframing resistance. New York: Haworth.
- Groh, D. R., Jason, L. A., Davis, M. I., & Olson, B. D., & Ferrari, J. R. (2007). Friends, family, and alcohol abuse: An examination of general and alcohol-specific social support. *American Journal on Addictions, 16*, 49-55.
- Grusec, J. E., & Goodnow, J. J. (1994). Impact of parental discipline methods on the child's internalization of values: A reconceptualization of current points of view. *Developmental psychology, 30*, 4-19.
- Guilamo-Ramos, V., Bouris, A., Jaccard, J., Lesesne, C. A., Gonzalez, B., et al. (2009). Family mediators of acculturation and adolescent sexual behavior among Latino youth. *Journal of Primary Prevention, 30*, 395-419.
- Guilamo-Ramos, V., Jaccard, J., Pena, J., & Goldberg, V. (2005). Acculturation-related variables, sexual initiation, and subsequent sexual behavior among Puerto Rican youth. *Health Psychology, 24*, 88-95.

- Haddad, Y. (1997). A century of Islam in America. *Hamdard Islamicus*, 21, 1-12.
- Healthy People 2020. (2010). *Framework: The vision, mission, and goals of Healthy People 2020*. Retrieved February 10, 2012 from <http://healthypeople.gov/2020/consortium/HP2020Framework.pdf>
- Henriksen, L., & Jackson, C. (1998). Anti-smoking socialization: Relationship to parent and child smoking status. *Health Communication*, 10 (1), 87-101.
- Herman, M. R., Dornbusch, S. M., Herron, M. C., & Herting, J. R. (1997). The influence on family regulation, connection, and psychological autonomy on six measures of adolescent functioning. *Journal of Adolescent Research*, 12 (1), 34-67.
- Hjrape, J. (1997). What will be Chosen from the Islamic Basket. *European Review*, 5, 267-274.
- Hofferth, S. L., & Sandberg, J. E. (2001). How American children spend their time. *Journal of Marriage and the Family*, 63, 295-308.
- Ibn Majah, M. (2007). *Sunan Ibn Majah*. Karatshi: Darus Salam.
- Ibn 'Asakir, Ali. (1954). *Tarikh Madinat Dimashq*. Damascus: Al- matba'ah Al-hashimiyyah.
- Inman, A., Ladany, N., Costantine, M., & Morano, C. (2001). Development and preliminary validation of the cultural values conflict scale for South Asian Women. *Journal of Counseling Psychology*, 48, 17-27.
- Isalm, S. M. S., & Johnson, C. A. (2003). Correlates of smoking behavior among Muslim Arab-American adolescents. *Ethnicity & Health*, 8(4), 319-337.
- Jaccard, J., & Dittus, P. J. (2000). Adolescent perceptions of maternal approval of birth control and sexual risk behavior. *American Journal of Public Health*, 90(9), 1426-1430.

- Jaccard, J., Dittus, P. J., & Gordon, V. V. (2000). Parents-adolescent congruency in reports of adolescent sexual behavior and in communications about sexual behavior. *Child Development, 69*, 247-261.
- Jaccard, J., Dittus, P., & Gordon, V. (1996). Maternal correlates of adolescent sexual and contraceptive behavior. *Family Planning Perspectives, 28*, 159-165.
- Jaccard, J., Dittus, P., & Gordon, V. (1996). Maternal correlates of adolescent sexual and contraceptive behavior. *Family Planning Perspectives, 28*, 159-165.
- Jessor, R. (1984). Adolescent development and behavioral health. In J. D. Matarazzo, S. M. Weiss, J. A. Heard, N. E. Miller, & S. M. Weiss (Eds.), *Behavioral Health: A handbook of health enhancement and disease prevention* (PP. 69-90). New York: Wiley.
- Jones, S. (2011). The influence of environment. *The Science of Adolescent Risk –Taking: Workshop Report*. Institute of Medicine and National Research Council of the National Academics. Washington, D C: The National Academies Press.
- Kao, T. A., Guthrie, B., & Loveland-Cherry, C. (2007). An international approach to understanding Taiwanese American adolescent girls and their mothers' perceptions about sexual health. *Journal of Family Nursing, 13*(3), 312-332.
- Kao, T. A., Guthrie, B., & Loveland-Cherry, C. (2007). An international approach to understanding Taiwanese American adolescent girls and their mothers' perceptions about sexual health. *Journal of Family Nursing, 13*(3), 312-332.
- Keating, D. (1990). Adolescent thinking. In S. Feldman & G. Elliot (Eds.), *At the threshold: The developing adolescent* (pp. 54-89). Cambridge, MA: Harvard University Press.
- Kenemore, E., & Spira, M. (1996). Mothers and their adolescent daughters: Transitions and transformations. *Child and Adolescent Social Work Journal, 13*, 225-240.

- Klein, D. M., & White, J. M. (2008). The symbolic interaction framework. In D. M. Klein & J. M. White, *Family Theories* (pp. 93-120). Thousand Oaks, CA: Sage.
- Koenig, H. G., McCullough, M. E., and Larson, D. B. (2001). *Handbook of Religion and health*. New York: Oxford University press.
- Kotchick, B. A., Dorsey, S., Miller, K. S., & Forehand, R. (1999). Adolescent sexual risk-taking in single-parent ethnic minority families. *Journal of Family Psychology, 13*(1), 93-102.
- Kristjansson, A., L., Sigfusdottir, I. D., Allegrante, J. P., & Helgason, A. R. (2008). Social correlates of cigarette smoking among Icelandic adolescents: A population-based cross-sectional study. *BMC Public Health, 8*, 86.
- LaRossa, R., & Reizes, D. C. (1993). Symbolic interactionism and family studies. In P. G. Boss, W. J. Doherty, R. LaRossa, W. R. Schumm, & S. K. Steinmetz (Eds.), *Sourcebook of Family Theories and Method: A conceptual approach* (pp. 135-163). New York, Plenum.
- Larson, R. W., Richards, M. H., Moneta, G., Holmbeck, G., & Duckett, E. (1996). Changes in adolescent's daily interactions with their families from ages 10 to 18: Disengagement and transformation. *Developmental Psychology, 32*, 744-754.
- Lefkowitz, E. S. (2002). Beyond the yes-no question: measuring parent-adolescent communication about sex. *New Directions for Child Development, 97*, 43-56.
- LeVine, R. (1980). A cross-cultural perspective on parenting. *Parenting in a Multicultural Society* (pp. 17-26). New York: Longman.
- Lovato, C. Y., Litrownik, A. J., Elder, J., & Nunez-Liriano, A. (1994). Cigarette and alcohol use among migrant Hispanic adolescents. *Family Community Health, 16*, 18-31.
- Ma, G., Tan, Y., Toubbeh, J., Su, X., Shive, S., & Lan, Y. (2004). Acculturation and smoking behavior in Asian- American populations. *Health Education Research, 19*, 615-625.

- Mackey, E. R., & La Greca, A. M. (2007). Adolescents' eating, exercise, and weight control behaviors: Does peer crowd affiliation play a role? *Journal of Pediatric Psychology*, 32(1), 13-23.
- Maiter, S., & George, U. (2003). Understanding context and culture in the parenting approaches of immigrant South Asian Mothers. *Affilia*, 18, 411-428.
- Mallinckrodt, B., McCreary, B. A., & Robertson, A. K. (1995). Co-occurrence of eating disorders and incest: The role of attachment, family environment, and social competencies. *Journal of Counseling Psychology*, 42, 178-186.
- Maloof, P. S., & Ross-Sheriff, F. (2003). *Muslim Refugees in the United States: A Guide for Service Providers*. Washington, DC: Center for Applied Linguistics.
- Marin, B. V., & Flores, E. (1994). Acculturation, sexual behavior, and alcohol use among Latinas. *International Journal of Addictions*, 29, 1101-1114.
- Marks, L. (2006). Religion and family relational health: An overview and conceptual model. *Journal of Religion and Health*, 45, 603-618.
- McNeely, C., Shew, M. L., Beuhring, T., Sieving, R., Miller, B. C., & Blum, R. M. W. (2002). Mothers' influence on the timing of first sex among 14- and 15-year-olds. *Journal of Adolescent Health*, 31, 256-265.
- Miller, B. C. (1998). *Families matter: A research synthesis of family influences on adolescent pregnancy*. Washington, DC: National Campaign to Prevent Teen Pregnancy.
- Miller, B. C. (2002). Family influences on adolescent sexual and contraceptive behavior. *Journal of Sex Research*, 39, 22-26.
- Miller, B. C., Benson, B., & Galbraith, K. A. (2001). Family relationships and adolescent pregnancy risk: A research synthesis. *Developmental Review*, 21, 1-38.

- Miller, K. S., Forehand, R., & Kotchick, B. A. (1999). Adolescent sexual behavior in two ethnic minority samples: The role of family variables. *Journal of Marriage and the Family*, 48, 777-782.
- Moghadam, V. M. *Modernizing women: Gender and social change in the Middle East* (2nd edition). Lynne Rienner.
- Motl, R. W., et al. (2007). Perceptions of physical and social environment variables and self-efficacy as correlates of self-reported physical activity among adolescent girls. *Journal of Pediatric Psychology*, 32(1), 6-12.
- Muller, C. (1998). Gender differences in parental involvement and adolescents' Mathematics achievement. *Sociology of Education*, 71, 336-356.
- Muslim, I. A. (2007). *Sahih Muslim*. London: Adams Publishers and Distributers.
- Muuss, R. E. (2006). Jean Piaget's cognitive theory of adolescence. *Theories of Adolescence* (pp. 158-165). New York: McGraw-Hill.
- Muuss, R. E. (2006). Theoretical expansion and empirical support for Erikson's theory. *Theories of Adolescence* (pp. 58-68). New York: McGraw-Hill.
- Myers-Walls, J., Myers-Bowman, K. S. & Posada, G. (2006). Parenting practices worldwide. *Families in Global and Multicultural Perspectives* (pp. 147-166). Newburey Park: Sage.
- Naidoo, J., & Davis, C. (1988). Canadian South Asian women in transition: A dualistic view of life. *Journal of Comparative Family Studies*, 19, 311-327.
- Neumark-Sztainer, D., Hannan, P., Story, M., Croll, J., & Perry, C. (2003). Family meal patterns: Associations with sociodemographic characteristics and improved dietary intake among adolescents. *Journal of American Diet Association*, 103, 317-322.

- Nolin, M. J., & Peterson, K. K. (1992). Gender differences in parent child communication about sexuality: An exploratory study. *Journal of Adolescent Research*, 7(1), 59-79.
- Oh, I. (2010). Motherhood in Christianity and Islam: Critiques, realities, and possibilities. *Journal of Religious Ethics*, 38, 638-653.
- Padilla-Walker, L. M. (2007). Characteristics of Mother-child interactions related to adolescents' positive values and behaviors. *Journal of marriage and family*, 69 (3), 675-686.
- Park, W., & Grindel, G. C. (2007). Korean American mother and daughter communication on women's health topics. *Journal of Cultural Diversity*, 14 (1), 4-11.
- Patton, M. (2002). *Qualitative Research & Evaluation Methods* (3rd ed.). Thousand Oaks, CA: Sage.
- Pearson, J., Muller, C., & Frisco, M. L. (2006). Parental involvement, family structure, and adolescent sexual decision making. *Sociological Perspectives*, 49 (1), 67-90.
- Philips, B. (1988). *The Evolution of Fiqh*. Riyadh: International Islamic Publishing House.
- Piaget, J. (1969). The intellectual development of the adolescent. In G. Gaplan, & P. Lebovic (Eds.), *Adolescence: Psychological Perspective* (pp. 125-168). New York: Basic Books.
- Pick, S., & Palos, P. A. (1995). Impact of the family on the sex lives of adolescent. *Adolescence*, 30, 667-675.
- Ransdell, L., Dratt, J., Kennedy, C., O'Neill, S., & DeVoe, D. (2001). Daughters and mothers exercising together (DAMET): a 12-week pilot project designed to improve physical self-perception and increase recreational physical activity. *Women & Health*, 33(3/4), 113-129.
- Rashid, H. M. (1988). The socialization of Muslim Children in America: Toward A conceptual Framework. *The American Journal of Islamic Social Sciences*, 5(2), 205-217.

- Reis, J. (1996). A descriptive study of African American mother-child communication about drugs and health. *Journal of Comparative Family Studies*, 27(3), 485-498.
- Resnick, M. D., et al. (1997). Protecting adolescents from harm: Findings from the National Longitudinal Study on adolescent health. *Journal of American Medical Association*, 278, 823-832.
- Resnick, M. D., Harris, L. J., & Blum, R. W. (1993). The impact of caring and connectedness on adolescent health and well-being. *Pediatrics and Child Health*, 29(1), 3-9.
- Rice, V., & Kulwicki, A. (1992). Cigarette use among Arab Americans in the Detroit metropolitan area. *Public Health Reports*, 107, 589-594.
- Rich, M. (2011). The influence of environment. *The Science of Adolescent Risk –Taking: Workshop Report*. Institute of Medicine and National Research Council of the National Academics. Washington, D C: The National Academies Press.
- Roald, A. S. (2001). Research on Muslims. *Women in Islam: The Western Experience* (pp. 5-22). London: Routledge.
- Roberts, D. F., Foehr, U. G., & Rideout, V. (2005). *Generation M: Media in the lives of 8-18 years-old*. Menlo Park, CA: Kaiser Family Foundation.
- Rossow, I., Rise, J. (1994). Concordance of parental and adolescent health behaviors. *Social Science Medicine*, 7, 34-43.
- Ross-Sheriff, F., Tirmazi, M. T., & Walsh, T. R. (2007). Cultural and religious contexts of parenting by immigrant South Asian Muslim mothers. *Immigrant Families in Contemporary Society* (pp. 194-221). New York: Guilford.

- Savin-Williams, R. C., & Berndt, T. (1990). Friendships and peer relations during adolescence. In S. S. Feldman & G. R. Elliot (Eds.), *At the threshold: The developing adolescent* (pp. 277-307). Cambridge, MA: Harvard University Press.
- Schleifer, A. (1986). *Motherhood in Islam*. Cambridge: Islamic Academy.
- Schwartz, S., Darwish-Yassine, M., & Wing, D. (2005). Cancer diagnosis in Arab Americans and Arabs outside the United States. *Ethnicity & Disease, 15*, 1-8.
- Shelley, D., Fahs, M., Scheinmann, R., Swain, S., Qu, J., & Burton, D. (2004). Acculturation and tobacco use among Chinese Americans. *American Journal of Public Health, 94*, 300-307.
- Silverman, D. (2000). Interpreting qualitative data: Methods for analyzing talk, text, and interaction (3rd ed.). Thousand Oaks, CA: Sage.
- Smith, J. (2003). *Women's Issues in American Islam*. The Duncan Black MacDonald Center for the Study of Islam and Christian – Muslim Relations. Retrieved May 17, 2003 from [http:// macdonald.hartsem.edu/smithart1.htm](http://macdonald.hartsem.edu/smithart1.htm)
- Song, Y., Hofstetter, R., Hovell, M., Paik, H., Park, H., Lee, J., et al. (2004). Acculturation and health risk behaviors among Californians of Korean descent. *Preventive Medicine, 39*, 147-156.
- Steinberg, L., & Silk, J. S. (2002). Parenting Adolescents. In M. N. H. Bomstein (Ed.), *Handbook of Parenting: Vol. 1. Children and parenting* (2nd ed., pp. 103-133). Mahwah, NJ: Erlbaum.
- Stolley, M. R., & Fitzgibbon, M. L. (1997). Effects of an obesity prevention program on the eating behavior of African American mothers and daughters. *Health Education and Behavior, 24*, 152-164.

- Straus, M. (2007). *Adolescent Girls in Crisis: Intervention and Hope*. New York: W. W. Norton & Company.
- Sussman, S., Dent, C., McAdams, L., Stacy, A., Burton, D., & Flay, B. (1994). Group self-identification and adolescent cigarette smoking: A 1-year prospective study. *Journal of Abnormal Psychology, 103*, 576-580.
- Sussner, K. M., Lindsay, A. C., Greaney, M. L., & Peterson, K. E. (2008). The Influence of immigrant status and acculturation on the development of overweight and Latino families: A qualitative study. *Journal of Immigrant Minority Health, 10*, 497-505.
- The Institute of Medicine (2002). *Unequal Treatment: Confronting Racial and Ethnic Disparities in health Care*. Retrieved January 15, 2007, from <http://www.iom.edu/?id=4475>.
- Tibbs, T., Haire-Joshu, D., Schechtman, K. B., Brownson, R. C., Nanney, M. S., & Houston, C., et al. (2001). The relationship between parental modeling, eating patterns, and dietary intake among African-American parents. *Journal of the American Dietetic Association, 101*, 535-541.
- Tummala-Narra, P. (2004). Mothering in a foreign land. *The American Journal of Psychoanalysis, 64*, 167-182.
- Udry, J. (1989). *Biosocial models of human sexual behavior*. Paper presented at annual meeting of National Council on Family Relations, New Orleans, LA.
- Usher-Seriki, K. K., Bynum, M. S., & Callands, T. A. (2008). Mother-daughter communication about sex and sexual intercourse among middle-to upper-class African American girls. *Journal of Family Issues, 29*(7), 901-917.

- Van Manan, M. (1990). *Researching Lived Experience: Human Science for an Action Sensitive Pedagogy*. New York: State University of New York.
- Wayne County Health Department. (1994). *Arab community in Wayne County, Michigan: Behavior risk factor survey (BRFS)*. East Lansing, MI: Michigan State University, Institute for Public Policy and Social Research.
- Weiss, G. L., Larsen, D. L., & Baker, W. K. (1996). The development of health protective behaviors among college students. *Journal of Behavioral Medicine, 19*, 143-161.
- World Health organization-EMRO. (2001). *Activating the Role of Religion during the Last Year in Combating the Tobacco Epidemic*. World Health Organization, Regional Office for the Eastern Mediterranean. Retrieved April 11, 2002 from <http://www.emro.who.int/tfi/WNTD2001/IslamicRulings.htm>.

Appendix A - Interview Questions

Questions for the mother

1. Do you speak English?
2. How can you define “healthy behavior”?
 - ✓ Do you think you follow healthy eating behavior?
 - ✓ Do you think you are physically active?
 - ✓ Do you smoke?
3. Do you have any health problem?
4. What do think mostly influence your values regarding these health behaviors: religion, or culture of origin, or the American culture?
5. What do you think about the influence of Islam on your health values?
 - ✓ How are your health values influenced by Islamic beliefs?
 - ✓ How are your health values influenced by religious practices?
6. How do you feel about the influence of your culture of origin on your health values?
7. How do you feel about the influence of the American culture on your health values?
 - ✓ Loss of family support.
 - ✓ Value conflict.
 - ✓ The influence of Sep, 11, 2001 event.
8. How can you describe your relationship with you daughter?
 - ✓ How close do you feel you are to your daughter?
 - ✓ How supportive do you feel your relationship to your daughter?
 - ✓ How do you feel about the mutuality in the relationship?

- ✓ Do you share or impose your values on your daughter?
9. What do you think about the time (amount & quality) you spend with your daughter?
 10. What do you think about your knowledge about where your daughter is and with whom she is?
 11. What is your opinion about the communication (content & process) you have with your daughter regarding different health behaviors?
 12. How do you think your values influence the mother-daughter relationship and mothering practices?
 13. What do you think about your influence on your daughter's health behavior?
 14. How do you think your daughter perceives this relationship and these maternal practices?
 15. How does your daughter perceive you as a role model for different health behaviors?
 16. How do you feel about your daughter's perception of your values regarding smoking, eating behavior, and physical activity?
 17. What do you think about sex education classes at schools?
 18. What advice do you have for immigrant Muslim mothers who are raising their adolescent daughters in the United States?
 19. How old are you?
 20. Do you have a job?
 21. How long have you been in the United States?
 22. How do you think your daughter perceives her father's health values?

Questions for the Daughter

1. How do you describe your relationship with your mother?
 - ✓ How close do you feel you are to your mother?
 - ✓ How supportive and positive do you perceive your relationship with your mother?
 - ✓ Do you see mutuality in this relationship?
 - Does your mother impose or share her values with you?
 - Do you think your mother accept health information from you?
2. What do you think about the time (the amount & the quality) you spend with your mother?
3. What do you think about your mother's knowledge about where you are and with whom you are?
4. What is your opinion about the communication (the content & the process) you have with your mother regarding different health behaviors?
5. How can you define "healthy behavior"?
 - ✓ Do you think you follow healthy eating behavior?
 - ✓ Do you think you are physically active?
 - ✓ Do you smoke?
6. Do you have any health problem?
7. What do you think about your mother's influence on your health behavior?
8. What is your opinion regarding having your mother as a role model for different health behaviors?
9. How do you feel about your mother's health values regarding smoking, eating behavior, and physical activity?

10. What do you think that mostly shape or influence your mother's health values: religion, culture of origin, or the American culture?
- ✓ Do you face value conflict with your mother?
11. What do you think about the influence of Islam on your health values?
- ✓ How are your health values influenced by Islamic beliefs?
 - ✓ How are your health values influenced by religious practices?
12. How do you feel about the influence of your mother's culture of origin on your health values?
13. How do you feel about the influence of the American culture on your health values?
- ✓ Are you in Public school or Islamic school?
 - ✓ Have you attended sex education classes?
 - ✓ Do you have American friends or only American Muslim friends?
14. What advice do you have for adolescent girls in the United States? Regarding their relationship with their mothers and their health behaviors.
15. How old are you?
16. What is your arrangement in the family?
17. In what grade you are?
18. Do you have a job?
19. What do you think about your father's health values?

