

TIME ORIENTATIONS OF INDIAN MOTHERS AND WHITE NURSES

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Cultural values are important for nurses because beliefs and values have been shown to influence health behaviours (e.g., pain perception: Bates, 1987; perinatal care: Lee, 1986). Little is known about how nurses' values relate to those of people in different ethnic groups, such as Native Indians (Brink, 1984; Tripp-Reimer, 1984). Furthermore, relatively little is known about the current values of North American Indian peoples and no formal studies have been done with Canadian Indians. This study is a first step in describing a particular value: time orientation.

Time orientation was conceptually structured by Kluckhohn and Strodtbeck (1961) as the preferential ordering of time into the Past, the Present and the Future. Time orientations are thought to be a problem when nurse - client differences or misinterpretations hamper health care interactions (Tripp-Reimer, 1984). For example, it is generally held that there are differences in time orientations between Canadian Indians and their predominately White health care providers. Specifically, a White health care professional could have a Future-oriented perspective in responding to an Indian person — failing to perceive the situation from the Indian perspective of Past or Present-orientation (Brant, 1983; England, 1986). The potential for such differences and misunderstandings is the greatest among recent Indian migrants to predominately White cities and among northern Indians where there is a high turn-over of White health care workers (Young, 1988). Basic descriptive research is needed before the hypothesis that ethnically-influenced time orientation differences hamper health care can be tested.

Review of the Literature

A theoretical construct of time

The earliest research on the construct of time was conducted by Kluckhohn and Strodtbeck (1961) among White and American Indian groups in the mid-

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west. References to their value-based, theoretical construct of time and findings are the most common citations in the cross-cultural health care literature (Brink, 1984; Orque, Block & Monroy, 1983; Papajohn & Spiegel, 1975; Tripp-Reimer, 1984).

Other constructs of time are: perceived elapsed time or subjective time; clock time or objective time; and the relationship of these to each other or to consciousness (Newman, 1982; for a review of these constructs see Nojima et al., 1987). Subjective time is somewhat related to the Kluckhohn and Strodtbeck value orientation construct of time: it deals with the size or duration of the temporal Present, but it is not conceptually linked to either distant Past or Future orientations. Although objective time has a Past, Present and Future, it is missing the value construct. Therefore, these constructs of time were not used in this study.

From the value orientation perspective, cultures in which temporal focus is the Past emphasize tradition; those that focus on the Present place less emphasis on history or tradition; and those that focus on the Future emphasize planning for change at up coming points (Papajohn & Spiegel, 1975). The Kluckhohn and Strodtbeck (1961) study demonstrated that various ethnic groups all value the Past, the Present, and the Future, but they differ in the emphasis placed on each. They compared several ethnic groups residing in the same geographic area of the United States. They found that two groups of English-speaking Americans rank-ordered time as Future > Present > Past. In contrast, two groups of North American Indians ranked time in the order of Present > Past > Future.

Although subsequent work tends to confirm the influence of ethnicity (Brink, 1984; Tripp-Reimer, 1984), time orientation has been found to be affected by other factors. For example, Roberts and Greene (1971), using stories written about pictures, reported that time orientation was dependent upon the context of the situation in 112 adolescents in three ethnic groups. Extending the more unidimensional work of Kluckhohn and Strodtbeck (1961), they found that the American-Indian and Spanish-American groups were more Past oriented for religious content, but not on social content when compared with Anglo-Americans.

Time orientation has also been shown to be influenced by state of wellness (Nojima et al., 1987); age (Newman, 1982; Roberts & Greene, 1971); and gender (Kluckhohn & Strodtbeck, 1961; Newman, 1982; Roberts & Greene, 1971). However, whether or not other socio-demographic factors influence the Past-Present-Future construct of time is not known.

In summary, because time orientations vary widely between cultural groups, within care-giving contexts and by age group, states of wellness and

gender, the natural tendency is for nurses to generalize to the client from their own perspectives. This "nurse's perspective" could include personal, ethnically-influenced values and broad assumptions about a client's values, based on the nurse's perceptions of the client's ethnic group. Such potentially inaccurate views or over-generalizations could interfere with communications and, therefore, health care outcomes (Hein, 1980). A clear understanding of both nurse and client factors influencing time orientations would lead to more effective interaction.

Culture, acculturation and ethnicity

The concepts of culture, acculturation and ethnicity are central to the understanding of values. Culture is the entire lifeways of a human group and, as such, includes values, beliefs, customs and behaviours learned and shared by the interacting group (Tripp-Reimer, 1984). The word *culture* is sometimes used interchangeably with *ethnic group*. Ethnic group is commonly used when there are several sets of cultural lifeways in simultaneous or close play, as with most Euro-Canadians or Canadian Indians today. However, ethnicity has many facets and many researchers use race and language as indicators (Smith, 1980). Most importantly, ethnicity includes the notions of degree of awareness of the ethnic group and affiliation with the ethnic group and its culturally influenced beliefs and values (Peterson, 1978). Ethnicity is an important factor in providing high quality nursing care (Kub, 1986).

Acculturation is a process that occurs when people of different cultures come in close continual contact: it involves changes in the cultural patterns of one or both people (Richman, Gavira, Flaherty, Birz, & Wintrob, 1987). This phenomenon has stages, degrees and several possible outcomes; for example, assimilation, integration, separation and marginalization (Berry, 1980). The process comes into play when a White woman enters the nursing profession. She integrates the values and beliefs of the White health care sub-culture with those she held before entering nursing and develops an awareness of herself as a nurse. Acculturation also comes into play when a native person leaves her place of birth and comes to a large White city. For such a native woman, cultural values such as time orientation might be altered toward the White values (assimilation); balanced between native and White perspectives (integration); adhered to at home while adhering to White ways at work (separation); or, they could become confused in both White and native settings (marginalization).

Time from Indian, White, and nurse perspectives

Time, according to Mohawk psychiatrist Brant (1983), is grounded in Past-oriented traditions and beliefs. In contrast, White health care workers' Present-oriented values are based on rigid protocols and scheduled,

seemingly context independent appointments, medications or treatments. Health care workers' Future orientation is related to prevention of illness and complications; this runs counter to the Indian beliefs in maintaining a proper balance among all things and awaiting the right time for specific health care actions. For example, a Cree woman who personally did not wish to have another child, waited for the right time for her tubal ligation. In consideration of the Past-oriented traditions of her family and village, the right time was after her next child.

White nurses' time orientations are believed to be similar to those of their ethnic group. In health care contexts however, health care professionals are thought to have shared, strongly grounded beliefs about the "correct" time orientations. For example, in relation to a severe traumatic injury, Present time orientation is highly valued. In relation to preventive actions for health promotion, a strong Future orientation is held. The Past is valued only as a factor that will influence the present crisis or future health.

"Indian time" is a White term developed out of the misunderstandings that have arisen when Indian and White time orientations have come into conflict. These misunderstandings cluster around the White Present and Future-oriented views. There is a long history of such misunderstandings in the Canadian North (Young, 1988).

Method

The purpose of this study is to describe time orientations with particular reference to health care among nurses, Canadian Indians and Whites; to compare time orientations among groups; and to explore the relationships with selected socio-demographic factors. If Canadian Indians, Whites and nurses have the same values as their counterparts in the United States of 30 years ago and if acculturation theory is correct, the following should hold true.

1. White nurses will be more Future and Present oriented than the Canadian Indians.
2. Indians will be more Past oriented than the Whites.
3. Indians recently migrated to an urban center will be more Past-oriented than the rural Indian group; and,
4. White nurses' time orientations will be different from those of other Whites.
5. No group will differ from their expected time orientation pattern (Indian groups = Present > Past > Future; White groups = Future > Present > Past); and,
6. There will be variations in time orientation by the context of the situation.

Populations, settings and subjects

Time orientations vary by gender. Only women were studied for three reasons. First, most nurses are women. Secondly, among Whites, the responsibility for family health care is primarily the responsibility of the mother (Heller, 1986). Thirdly, among Indian groups, women also bear the primary responsibility for health care: grannies (respected female elders) and aunts share the responsibilities with young mothers. Selection of women with young children increased the likelihood of recent interactions with the health care system for perinatal and well-child care, or acute illness or injury treatment.

Ethnicity was determined by ancestry and subject-ascription (Obidinski, 1978; Sorofman, 1986). Whites were persons of European ancestry, born in or residing in Canada for most of their lives who considered themselves to be "Euro-Canadian". Canadian Indians were of primarily Indian ancestry, who considered themselves to belong to a particular Indian group, such as the Cree or the Ojibway.

Informed, written consent was obtained from a total of 131 mothers. Assent was also obtained from the relevant tribal council, native organizations, elders or nursing departments prior to data collection. The sample included five groups. Two groups were made up of North American Native Indians. Three groups contained women from the dominant North American cultural group referred to as Euro-Canadian Whites, because of their ancestry. The first group included 30 Cree Indian mothers living in an isolated, sub-arctic community (*rural Cree*). The second group included 21 Indian mothers who were purposively selected from an urban pantribal community of recent migrants from across Canada (*urban Indians*). Informal networks and snowballing were used. Data from three of the Urban Indians were incomplete (2) or did not meet our ethnicity criteria (1) and were not included in analyses — leaving 18 in the group. Twenty-one *urban White* Euro-Canadian mothers were domicile-matched with the urban native Indian group and served as the third group. The fourth group was made up of 30 maternal-child *nurses* working at the referral hospitals for the Cree group in a moderate-sized city. The fifth group comprised 30 Euro-Canadian women who delivered at one of the referral hospitals (*new mothers*). Subjects in groups one, four and five were randomly selected from available Public Health, personnel and clinic lists, respectively.

The new mothers acted as a comparison group for the nurses with whom they were similar, except for acculturation to the health care sub-culture (nursing education and health care system experiences). Both of these groups were White, mothers, in their childbearing years and had a similar

Table 1
WVOQ Time Orientation Questions*

Time Orientation	Child Training	Expectations About Change	Philosophy of Life	Health Care Services Innovations
Question	Some people were talking about the way children should be brought up. Here are three different ideas.	Three young people were talking about what they thought their families would have one day as compared with their fathers and mothers. They each said different things.	People often have very different ideas about what has gone before and what we can expect in life. Here are three ways of thinking about these things.	Some people in a community like yours think that health care services are changing from what they used to be.
Choices Past	Some people say that children should always be taught well the traditions of the past (the ways of the old people). They believe the old ways are best and that it is when children do not follow them too much that things go wrong.	The third one said: I expect my family to be about the same as the family of my father and mother or relatives. The best way is to work hard and plan ways to keep up things as they have been in the past.	Some people think that the ways of the past (ways of the old people or traditional ways) were the most right and the best, and as changes come things get worse. These people think the best way to live is to work hard to keep up the old ways and try to bring them back when they are lost.	Some people are unhappy because of the change. They feel that health care services should be kept as they were in the past.
Present	Some people say that children should be taught some of the old traditions (ways of the old people), but it is wrong to insist that they stick to these ways. These people	The second one said: I don't know whether my family will be better off, the same, or worse off than the family of my father and mother or relatives. Things always	Some people believe it best to give most attention to what is happening now in the present. They say that the past has gone and the future is much too	Some people feel that the old ways for health care services are best, but you just can't hang on to them. It makes life easier just to accept some changes as they come

Time Orientation	Child Training	Expectations About Change	Philosophy of Life	Health Care Services Innovations
Present continued	believe that it is necessary for children always to learn about and take on whatever of the new ways will best help them get along in the world of today.	go up and down even if people do work hard. So one can never really tell how things will be.	uncertain to count on. Things do change, but it is sometimes for the better and sometimes for the worse, so in the long run it is about the same. These people believe the best way to live is to keep those of the old ways that one can - or that one likes - but to be ready to accept the new ways which will help to make life easier and better as we live from year to year.	along.
Future	Some people do not believe children should be taught much about past traditions (the ways of the old people) at all, except as an interesting story of what has gone before. These people believe that the world goes along best when children are taught the things that will make them want to find out for themselves new ways of doing things to replace the old.	The first said: I expect my family to be better off in the future than the family of my father and mother or relatives if we work hard and plan right. Things usually get better for people who really try.	Some people believe that it is almost always the ways of the future - the ways which are still to come - which will be best, and they say that even though there are sometimes small setbacks, change brings improvements in the long run. These people think the best way to live is to look a long time ahead, work hard, and give up many things now so that the future will be better.	Some people are really pleased because of the changes in health care services. They feel that new ways are usually better than old ones, and they like to keep everything - even health care - moving ahead.

*Rank order of choices in the VVOQ is random with respect to time orientation. Questions are spread throughout questionnaire. Subjects select first and second preferences.

geographic domicile. The urban White mothers served as a matched comparison group for the urban Indians with whom they were socio-demographically similar (age, place of residence and socio-economic status) — except for ethnicity. Details of these socio-demographic similarities are reported elsewhere (Burke, Maloney, Pothaar & Baumgart, 1988).

Data collection tool

The Women's Value Orientation Questionnaire (WVOQ) was administered to all groups. There are two other measures of time orientation: the Kluckhohn and Strodtbeck (1961) Value Orientation Questionnaire (VOQ) and the Roberts and Greene (1971) story telling protocol. The WVOQ was the instrument of choice for this study as it is more specific to women than the VOQ and the story telling protocol of Roberts and Greene has only been used with adolescents. The WVOQ was developed from the VOQ and is an updated version, revised for use with women, with good reliability and validity (Burke and Maloney, 1986). The WVOQ has 19 items, four of which pertain to time orientation (Table 1). Subjects choose a first and second best answer, the remaining option is their third choice by default.

Procedure

Data collection was carried out by trained interviewers of similar ethnic background to the women who were interviewed. The full WVOQ is lengthy and involves some reading, so a few mothers had it read to them. Most completed it on their own with the researcher in the same room and a few completed it on their own and mailed it. For the first four groups, the WVOQ was given midway in a two-hour interview, concerning child rearing and child bearing beliefs and values, which was conducted in the subjects' homes. For the new mothers in the fifth group, the WVOQ was part of a two-hour maternal and newborn assessment which was completed post-partum in the hospital.

Analysis

Portions of the analysis are conceptually parallel to Brink's (1984) method; this is the most recent published detail on conceptually parallel VOQ analysis. In addition, other scoring procedures and statistics were used to exploit the strongly ordinal nature of the data. Chi squared (χ^2) tests, t-tests and analysis of variance (ANOVA) were done with SAS and BMDP computer software.

Results

Differences among groups

The first series of analyses compared time orientation preferences across the five groups. We did this to determine whether there were differences in choices across groups, and if these differences were grouped along the hypothesized ethnic and acculturation lines. Ethnically, we expected to find differences in White versus Indian time orientations. Ethnicity and acculturation theory would suggest differences between urban and rural Indian groups. Acculturation theory alone suggests differences between White nurses and White non-nurses.

Responses were scored as 1=Past, 2=Present or 3=Future. First and second choices were analyzed separately. A two-way ANOVA, with one between factor (5 groups) and one within factor (4 questions), was used to examine the differences in the first choice. Significant differences were found for groups ($F(4,120) = 27.56, p < .001$), questions $F(3,360) = 41.64, p < .001$, and the group by question interaction, $F(12,360) = 5.01, p < .001$. The difference across groups was explained by orthogonal contrasts. They revealed significant differences in choices between the urban Indian and the nurse groups ($F(3,360) = 6.17, p < .001$); between the rural Cree and the urban Indian groups ($F(3,360) = 7.25, p < .001$); and, between the urban White and new mother groups ($F(3,360) = 7.85, p < .001$). There were no differences in the first choice between the rural Cree and the nurses. These patterns did not support the study hypotheses of a difference in time orientation, based on ethnicity. Looking at the means for the first choices in Figure 1A, there was a split by geographic region. The two Urban groups were more Present/Past oriented compared with the other three groups which were more Present/Future oriented. Differences across questions or contexts are dealt with below.

When the analysis was repeated for the second-time orientation choices it was found that the groups responded in the manner predicted by the ethnic group differences hypotheses expected for the first choice. Again, significant differences were found across groups ($F(4,120) = 7.99, p < .001$), questions $F(3,360) = 18.71, p < .001$, and the group by question interaction, $F(12,360) = 5.20, p < .001$. The group differences were explained by orthogonal contrasts. As illustrated in Figure 1B, the urban Indians were more Present/Past oriented and the nurses were more Present/Future oriented ($F(3,360) = 8.93, p < .001$); the rural Cree were also more Present/Past oriented as compared to the nurses ($F(3,360) = 5.75, p < .001$); and, the urban Whites were more Present/Past oriented than the new mothers ($F(3,360) = 4.96, p < .001$). The rural Cree and urban Indians did not differ. In summary, the groups formed two clusters on their second choice of time orientations. One cluster included the

rural Cree, urban Indians, and urban Whites who were Present/Past oriented. The other cluster included the White nurses and new mothers who were Present/Future oriented. The differences across questions are dealt with below.

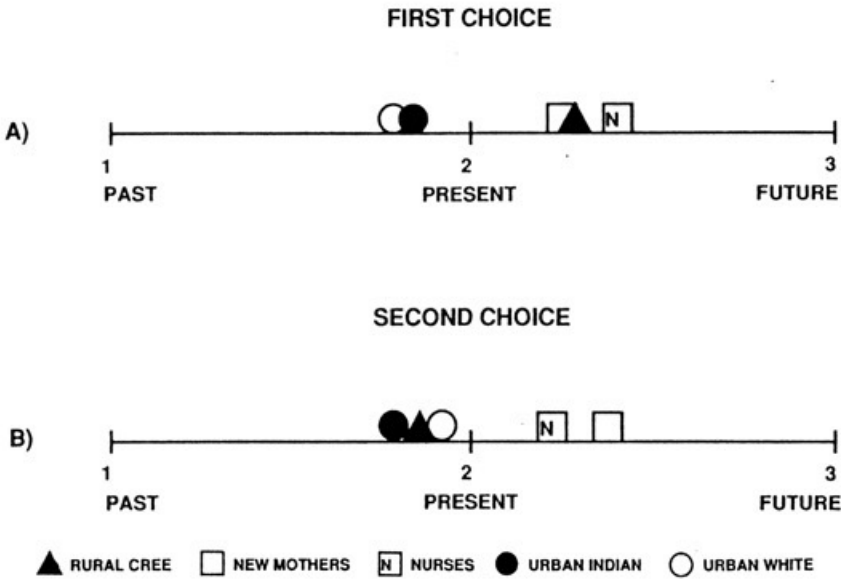


Figure 1
**Mean time orientation score for each of the five groups
for all questions for the first and second choice**

Overall differences from expected time orientation patterns

First choices compared with second choices were significantly different for each question within each group ($\chi^2(4, N=18-30) = 30.0-9.9$; $p=.05-<.0001$) with the exception of the expectation of change question for the urban Indians ($\chi^2(4, N=18) = 9$; $p=.06$). These results revealed a group consensus; there were different patterns of responses to the time orientation questions than would be expected by chance. The literature predicted patterns that would be expected for the Whites and North American Indians. These expected patterns and the patterns obtained from the five study groups are displayed in Table 2. Variations exist between the expected and the obtained Indian or White time orientation patterns. This finding was unexpected and T-tests were used to determine if these differences were significant. The degree of agreement between a subject's actual choices and her expected time orientation pattern was quantified. Where there was absolute agreement with the expected pattern, a subject's pattern score was 3 for the item. Where there was only a reversal of the first and second choices, leaving the third choice the same as in the expected pattern, a score of 2 was given. For each of these two patterns there is only one possible arrangement. The other four possible arrangements were considered disagreements between expected and obtained patterns and given a score of 1. A sum of these pattern scores across the four questions was computed. Perfect agreement with the

Table 2

Time Value Orientations: Expected and Actual

Group	Expected Patterns ¹	Observed Orientation ²	Agreement Score ³	Question Orientations ⁴			
				Child Training	Expectations	Philos. of Life	Health Care Innovations
Rural Cree	Pres>P>F	Pres>P>F	5.9	Pres>P>F	Pres>P>F	Pres>F>P	F>Pres>P
Urban Indians	Pres>P>F	Pres>P>F	6.2	Pres>P>F	F>P>Pres	Pres>P>F	F>Pres>P
Urban Whites	F>Pres>P	Pres>F>P	8.3	Pres>F>P	Pres>F>P	Pres>F>P	F>Pres>P
New Mothers	F>Pres>P	Pres>F>P	8.2	Pres>F>P	Pres>P>F	Pres>F>P	F>Pres>P
Nurses	F>Pres>P	Pres>F>P	8.2	Pres>F>P	Pres>P>F	Pres>F>P	F>Pres>P

¹Based on other studies, see Literature Review.²Most commonly observed pattern across questions.³All groups had significant t's = (18-30), 11.2 - 23.9; $p < .001$ for differences from expected pattern for that ethnic group; 12 = total agreement; 4 = disagreement.⁴All had significant χ^2 of first choice by second choice, pattern shown is cell with largest n for first, then second choice with the third choice by default.

expected pattern yielded a score of 12; total disagreement was given a score of 4.

In all groups each question had significant differences between what the literature predicted with regard to the ethnic group's time orientation and what we found ($t=(17-30) \ 35.0-3.0$; $p=.01 - \leq .0001$). As can be seen in Table 2, the groups' total time orientation pattern scores ranged from 8.3 to 5.9, showing significantly high disagreement between expected and obtained patterns.

The largest disagreement from expected overall time orientations was reported among the two Indian groups. This was confirmed by an ANOVA on the total time pattern difference scores among groups ($F(4, 121) = 19.12$ $p<.0001$). A Scheffe contrast test showed that the two Indian groups had significantly more disagreement from the expected pattern than did the three White groups.

For the health care innovation question all groups had a Future > Present > Past time orientation. It is notable that the health care innovation question showed a single pattern that was different from every group's overall pattern.

Responses and context

Because only the health care innovation question showed a different pattern from each groups' overall pattern, the final analysis was limited to an examination of group differences on this question. A one-way ANOVA, with one between factor (group), was calculated for first and second choice. Orthogonal comparisons were used to determine differences between groups.

For the first choice, differences across groups, $F(4,122) = 23.62$, $p<.001$, were explained by orthogonal comparisons. The urban Indian differed from the nurses $F(1,122) = 50.12$, $p<.001$ and the rural Cree $F(1,122) = 35.33$, $p<.001$; the urban Whites differed from the new mothers, $F(1,122) = 31.46$, $p<.001$; and, the Cree and nurses did not differ, $F(1,122) = 1.44$, N.S. These findings are summarized in Figure 2A which shows group means and illustrates that the new mothers, nurses, and rural Cree formed one cluster with a Future orientation and the Urban Indian and Whites formed a second cluster that was Present/Past oriented.

The results of the ANOVA repeated with the second choice showed the same split among the groups ($F(4,122)=11.06$, $p<.001$). Figure 2B shows group means and illustrates that on this second choice the urban groups were even more Past oriented, while the three other groups were more strongly Present oriented.

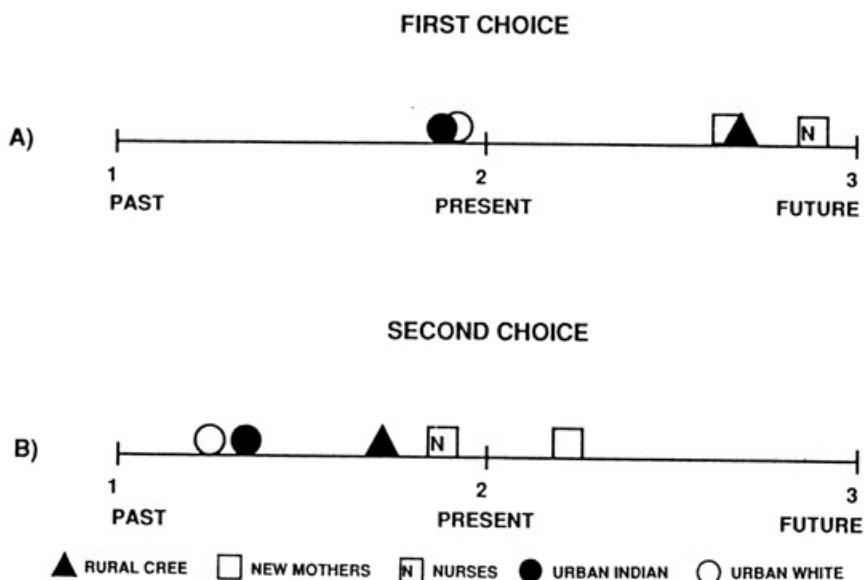


Figure 2
Mean time orientation score for each of the five groups
for health beliefs question for the first and second choice

Discussion

The ethnic differences between Indian and White groups were more subtle than expected. Differences occurred only at the second choice and not at the first choice, as had been predicted from previous study findings. That is, in their second choices, Indians were more Present/Past oriented and Whites were more Present/Future oriented. This is at variance with earlier work with different Indian and White groups (Kluckhohn & Strodtbeck, 1961). Differences in methods could account for some of the different findings. There were differences from earlier studies in our subjects' young age, their roles as mothers, limitation to females, the revisions made in the VOQ, and the Canadian sample. Alternatively, perhaps the time orientations of the ethnic groups have shifted over the 25 years since the last study.

The health care literature contains interpretations of Indian beliefs for Whites. Within this literature there has been an assumption that there is a common value set, or at least common themes (Brant, 1983; England, 1986; Tripp-Reimer, 1984). Conversely, most Indian persons and academics with Anthropology and Sociology backgrounds dispute this. For example, major differences between Cree groups living near to one another were described by Preston (1981). To the extent that the latter view is true, generalizations from one Indian group to another would be limited. These study results are ambiguous on this point. The urban Indian group contained a wide range of tribal groups, but had a close within-group consensus; this supports the view of a common set of values. However, the differences between the urban and

northern rural Indian groups supports the suggestion of major differences between Indian groups. Therefore, generalizations of these findings to the Indian population are not warranted.

The difference between groups on their first preferences for time orientation could be more readily explained by the place of residence than by ethnicity: urban vs. rural, suburban, small city. The strength of this variable is suggested by the differences found between the rural Indian group and the recent city migrant Indian group. It is further supported by the findings that the consistency within groups on time orientations was high among the two urban (Indian and White) groups. The strong effect of place of residence on time and other value orientations makes intuitive sense, but has not been substantiated in other studies. Given this finding, understanding the differences between the nurse group and other groups is limited because the nurse subjects all resided in a small city/suburban setting.

Context had a significant effect on how these mothers answered the questions. Within the context of health care services, all groups were more Future oriented than they were in other contexts. This finding extends the work of Roberts and Greene (1971) who found differences in time orientations in social as compared to religious contexts. Furthermore, it is consistent with the Burke et al. (1988) finding that, in matters of acute illness, mothers in all these groups prefer the White health care system and its values. Taken together with the Schilder (1981) and Nojima et al. (1987) findings on time perspective when ill or injured, it is reasonable to predict that health concerns, real or anticipated, fall outside of a person's usual time orientation.

The time orientations of the nurse group were at variance with those of client groups when there were differences in place of residence (urban vs. small city/village); ethnicity (Indian vs. White); and, context (general vs. health care). These young mothers were most strongly oriented toward the Present, regardless of group membership. However, there were significant, but subtle, variations toward either Present/Past or Present/Future orientations within most contexts. The exception was in the health care context, in which all groups had a strong Future orientation. Variations in time orientation were found across all five socio-cultural groups, in ways which could not be explained exclusively by ethnicity. Integration of the three factors, context, place of residence and ethnicity explains these results more fully.

In conclusion, the findings bring together separate aspects of the current literature on time orientations. The results suggest that neither ethnicity, place of residence, nor context can be considered in isolation when predicting a group's time orientation. Furthermore, because differences between groups were subtle, and because preferences in the health care context were unique, it may be concluded that the prediction of an individual's time orientation by group membership alone is not likely to be reliable in clinical use.

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RÉSUMÉ

Orientation dans le temps de mères amérindiennes et d'infirmières blanches

La notion de temps existe dans toutes les cultures, mais l'accent mis sur le passé, le présent et l'avenir diffère toutefois d'une culture à l'autre. Cette étude avait pour but de comparer l'orientation dans le temps d'infirmières dispensatrices de soins aux mères et aux enfants et de quatre groupes de clients, à l'aide du questionnaire d'orientation sur les valeurs des femmes. Les sujets retenus étaient des mères avec de jeunes enfants. Les groupes clients étaient constitués d'Indiens cris canadiens vivant en milieu rural et d'Indiens vivant en milieu urbain, et de jeunes mères euro-canadiennes vivant en milieu urbain. De façon générale, on a constaté chez tous les groupes une forte orientation vers le présent, sauf dans le contexte des soins de santé où l'orientation était plutôt tournée vers le futur. Toutefois, les différences subtiles observées entre les groupes pour ce qui est de l'orientation dans le temps étaient liées au lieu de résidence (milieu urbain ou rural), à l'ethnicité (Amérindiens ou Blancs) et au contexte (contexte général ou soins de santé). Toute prédiction par le personnel infirmier de l'orientation dans le temps d'une personne en fonction de sa seule appartenance ethnique n'est donc vraisemblablement pas fiable en milieu clinique.