MOBILE SELF-EFFICACY IN A CANADIAN NURSING EDUCATION PROGRAM

Richard F Kenny
Athabasca University
Courtenay, BC, Canada

Jocelyne M.C. Van Neste-Kenny
North Island College
Courtenay, BC, Canada

Pamela Burton
North Island College
Courtenay, BC, Canada

Caroline L. Park
Athabasca University
Winnipeg, MB, Canada

ABSTRACT

The purpose of this study was to assess the self-efficacy of nursing faculty and students related to their potential use of mobile technology and to ask what are the implications for their teaching and learning in practice education contexts. We used a cross-sectional survey design involving students and faculty in two nursing education programs in a Western Canadian college. 121 faculty members and students completed the survey in January, 2011. Results showed a high level of ownership and use of mobile devices among our respondents. Their median mobile self-efficacy score was 75 on a scale of 100, indicating that they are highly confident in their use of mobile technologies and prepared to engage in mobile learning.

KEYWORDS

Self-efficacy, motivation, mobile learning, nursing education, practice education

1. INTRODUCTION

Previously, we (Kenny, Park, Van Neste-Kenny, Burton, & Meiers, 2009a, 2009b, Park, Van Neste-Kenny, Burton, & Kenny, 2010) have argued that mobile learning (m-learning) could be effective to support the teaching and learning of nursing students at a distance. We subscribe to the definition of Koole (2009; Koole, McQuilkin & Ally, 2010) that m-learning is a process resulting from the interaction of mobile technologies, human learning capacities, and the social aspects of learning. In the nursing education context, m-learning supports more situated, experiential and contextualized learning and affords the use of up-to-date and accurate content and information (Kukulska-Hulme & Traxler, 2005). In nursing practice education, m-learning has the potential to bring the instructor, peers and resources together virtually at the point-of-care to support the students' safety and evidence-informed practice (Park et al., 2010).

This study was intended to provide further information on the current state of the use of mobile technology in nursing education and on the readiness of nursing instructors and students to engage in m-learning, especially in nursing practice education. As such, this is a replication, on a larger and broader scale, of a previous study (Authors, 2010). As before, we were interested in our respondents' level of motivation to engage in m-learning, and specifically, in the concept of self-efficacy (Bandura, 1997) as applied to mobile learning in nursing practice education.

Self-efficacy refers to the personal beliefs of individuals that they are capable of learning and performing particular behaviors and is domain specific (Bandura, 1997; Schunk, 2008). Students' perceptions of self-efficacy have been found to influence

their decisions about the choice of activity in which they engage, their emotional responses (e.g., stress and anxiety) when performing the behaviors, and their persistence in carrying out these actions (Bandura, 1997; Compeau & Higgins, 1995; Schunk, 2008). In the m-learning domain, mobile use is both enabled and constrained by the physical and functional components of the specific mobile devices. They are the medium through which learners interact and, therefore, impact their physical and psychological comfort levels (Koole, 2009). These components directly impact device usability and, therefore, individuals' ability to use their mobile device to engage in cognitive tasks, to locate and manipulate information, and to communicate and collaborate using social technologies (e.g., text messaging, email or audio conferencing). In an m-learning context, these applications in turn allow learners to interact in social and learning communities where they can acquire information and negotiate meaning. The ensemble of these components then defines the m-learning process and domain.

Individuals' self-efficacy judgments differ on three interrelated dimensions: magnitude, strength, and generalizability (Bandura, 1997, 2006; Compeau & Higgins, 1995). Magnitude refers to the level of task difficulty individuals believe they can attain. Those with high mobile self-efficacy would believe they were able to use their mobiles to accomplish difficult and sophisticated tasks, while those with low mobile self-efficacy would see themselves as only able to use them for limited and simple tasks. Self-efficacy strength refers to the level of confidence that individuals have regarding their ability to perform specific tasks; e.g., their level of confidence in their ability to easily learn and use the various features of, and applications provided by, mobile devices. Finally, self-efficacy generalizability reflects how much an individual's judgment is limited to a particular domain of activity. Individuals with high mobile self-efficacy generalizability would expect to be able to competently use a variety of different devices, while those with low computer self-efficacy generalizability may perceive their capabilities as limited to particular devices, especially those with which they have had experience.

While a significant body of research exists on learners' feelings of self-efficacy concerning computer technology, online learning, and even podcasting (e.g., Compeau & Higgins, 1995; Hodges, Stackpole-Hodges, & Cox, 2008; Johnson, 2005; Kao & Tsai, 2009; Koh & Frick, 2009; Liang and Wu, 2010; Loftus, 2009), this concept does not yet appear to have been examined in any detail in a mobile learning context.

2. METHODOLOGY

This study, then, replicates and extends our previous research (Authors, 2010) to assess the self-efficacy of nursing faculty and students concerning their use of mobile devices and to address the implications for their teaching and learning in practice education contexts. Our research questions were:

- In what ways are faculty and students currently using personal mobile devices in their teaching and learning?
- How do they foresee using personal mobile devices in teaching and learning in the future?
- To what degree is the level of mobile self-efficacy of nursing faculty and students related to their potential use of m-technology in teaching and learning?

To investigate these questions, we used a cross-sectional survey design involving students and faculty in two separate nursing education programs at a community college in Western Canada: a one-year Practical Nurse (PN) program and a four-year Bachelor of Science in Nursing (BSN) program. At the time of the survey, there were 55 students and 9 faculty members in the PN program and 134 students and 18 faculty members in the BSN Program, for a total of 216 potential participants. We developed an online survey to gather demographic information and mobile use data and to administer a mobile use self-efficacy questionnaire.

Bandura (1997, 2006) stresses that self-efficacy should measure judgments of capability that may vary across specific realms of activity. Our mobile self-efficacy questionnaire was based on a computer self-efficacy instrument (Compeau and Higgins, 1995) modified for a mobile learning context. This consisted of changing the question stem from "I could complete the job using the software package..." to (for students), "If I had a mobile device such as a smart phone or 3G phone (e.g., iPhone), I could use it in my Nursing program…" For instance, the wording for students in Question 1 was "If I had a mobile device such as a smart phone or 3G phone (e.g., iPhone), I could use it in my Nursing program if there was no one around to tell me what to do as I go". See Appendix A for the full set of questions. Bandura (2006) describes the assessment of self-efficacy as follows:

> In the standard methodology for measuring self-efficacy beliefs, individuals are presented with items portraying different levels of task demands, and they rate the strength of their belief in their ability to execute the requisite activities. They record the strength of their efficacy beliefs on a 100-point scale, ranging in 10-unit intervals from 0 ("Cannot do"); through intermediate degrees of assurance, 50 ("Moderately certain can do"); to complete assurance, 100 ("Highly certain can do") (p. 312).

As stipulated by Bandura, we asked our respondents to rate their confidence about the mobile use behaviour presented in each question from 0 – 10. If their answer was "No" (Could not do), they selected "0". If their answer was "Yes", they chose between 1 and 10, with "1" indicating only slight confidence and "10" showing total confidence ("Highly certain could do"). Therefore,

the scale ranges from a minimum of 0 to a maximum of 100. Nursing students and instructors scoring 0 believe that they are essentially incapable of learning and using mobile devices in their teaching and learning and those scoring 100 believe they are highly certain of their ability to learn and use mobile devices for this purpose. Bandura (2006) also stresses the need for item homogeneity within a domain-relevant scale. Cronbach's alpha was 0.941 indicating that the mobile version of the scale could be considered strongly internally consistent.

3. RESULTS

3.1. Demographic information

121 faculty members and students completed the survey in January, 2011, for an overall response rate of 56%. Table 1 provides the breakdown of respondents by program type, status as faculty or student, and gender.

Table 1. Demographic Information

Factor	Grouping	N	%
Program	PN	38	31.4
	BSN	83	68.6
Status	Faculty	17	14.0
	Students	104	86.0
Gender	Male	12	9.9
	Female	109	90.1

The BSN program was much larger than the PN program and provided over two thirds of the respondents in this study. Ninety percent were female, while slightly fewer than 10% were male.

Table 2. Age Data by Program

Status-Year	N	Mean	Min	Max	Skew
BSN Students Year 1	23	27.17	19	43	.800
BSN Students Year 2	21	24.90	20	50	2.841
BSN Students Year 3	16	28.69	21	52	1.293
BSN Students Year 4	11	32.64	22	49	.779
PN Students	33	34.39	19	53	.092
Regular Faculty	14	50.50	43	61	.331
Sessional Faculty	3	41.00	31	50	-.467
Totals	121	32.49	19	61	.599

PN students were substantially older than the BSN students on average and more uniform in age. The mean ages of the BSN students varied from an average of about 25 in the Year 2 group to nearly 33 in the Year 4 group. Overall, our student respondents tended to be mature adults.

3.2. Mobile Ownership and Use

The familiarity of ownership should impact users' assessment of their capability to use a mobile device and, therefore, mobile self-efficacy scores. Only 10 of our respondents (8%) - two faculty members and eight students - indicated that they did not own a mobile device. Table 3 shows which mobiles our respondents owned. About 15% owned a classic (phone only)

mobile, while 27% had a phone with a camera or MP3 player. Twenty-two percent possessed a smart phone (e.g., a Blackberry), while 24% had a 3G phone (e.g., an Apple iPhone). Just under 12% had "other" devices (such as an Apple iPod Touch or iPad), which provided them with email and internet access and nursing applications.

Among students, the types of devices owned were relatively uniform across program groups. Twenty-eight percent of BSN students and 30% of PN students owned a mobile with camera, while 24% of BSN students and 27% of PN students had a 3G phone. Faculty had a lower level of ownership with 11% owning a camera phone and 15 percent possessing a 3G phone.

Table 3. Type of Mobile Owned

	Mobile Type					
	Classic Cell	Cell / Camera	Smart Phone	3G Phone	Other	Total
BSN Students Year 1	7	4	4	7	1	23
BSN Students Year 2	2	8	8	3	0	21
BSN Students Year 3	2	6	3	4	1	16
BSN Students Year 4	0	2	5	3	1	11
PN Students	3	10	3	9	8	33
Regular Faculty	3	3	4	2	2	14
Sessional Faculty	1	0	0	1	1	3
Total	18	33	27	29	14	121

To explain their mobile self-efficacy, it was also important to detail how faculty and students used their devices in their daily lives as well as in teaching and learning in order. Table 4 shows which mobile features our respondents used weekly. Not surprisingly, the majority (83%) of respondents used the telephone function of their mobiles the most.

The number was not 100% because some respondents indicated buying their mobiles for emergency purposes only and other respondents may have instead tended to text more than telephone since text messaging (SMS) was the second most widely used feature at72%. Just under half (45%) of our respondents used their mobiles weekly to browse the Internet, while over one third used them for photography (37 %) or to do email (36%), and 21% to play games. Other uses included recording videos in the lab, listening to music, using the address book, alarm clock and calendar features, and keeping memos and lists.

Table 4. Mobile device features used at least once a week

Program	Faculty-Student	Telephone	Camera	Email	Browser	SMS	Audio MSG	Word pro	Health apps	Games	Other
BSN	Faculty	8	2	6	6	7	0	1	1	1	3
	Student	65	31	28	34	56	4	6	9	20	12
PN	Faculty	4	1	1	1	2	0	0	1	0	1
	Student	24	11	9	13	22	5	4	4	4	2
Totals		101	45	44	54	87	9	11	15	25	18

We also asked which features respondents used at least once weekly to support their learning or teaching (Table 5) and they reported this use to be about 65% of their total mobile use. Fifty-four percent used the telephone for educational purposes, while 39% used their devices for browsing and texting, and 30% for email. It was surprising that only 17% of this sample reported using their mobiles for health applications since, in our previous research (Authors, 2009a), nursing students rated drug reference programs as the most useful mobile feature.

Table 5. Mobile Features used in nursing education by program

Program	Faculty-Student	Telephone	Camera	Email	Browser	SMS	Audio MSG	Word pro	Health apps	Games	Other
BSN	Faculty	4	0	3	4	4	0	1	1	0	2
	Student	44	12	24	28	32	1	8	11	0	8
PN	Faculty	3	0	1	1	0	0	0	1	0	0
	Student	14	7	8	14	11	3	5	7	2	4
Totals		65	19	36	47	47	4	14	20	2	14

3.3. The Potential Use of Mobile Devices in Teaching and Learning

In the demographics section of the survey, our respondents were also asked to answer an open-ended question: What do you see as the potential uses of these technologies to support teaching and learning in the practice area? While space does not permit a full presentation of our qualitative data, we can report that our respondents made a wide range of comments about the perceived benefits and barriers to the use of mobile devices in their teaching and learning. This section presents the most common benefits and barriers expressed by the BSN faculty and students, who made up over two thirds of our respondents.

One major benefit noted by faculty and students for their teaching and learning was the use of mobile devices to provide quick, easy, and anytime access to current, professional information at the point of care. This included both the use of nursing resource applications such as drug guides and access to the Internet. This perceived importance of the use of mobiles to access resources is also supported by past research and our own studies (Authors, 2009a, 2009b). These comments by BSN students typify the comments made in this regard:

> Technology can support nursing practice such as accessing current information quickly to support practice decisions, reducing errors (i.e., using programs to check drugs and calculate doses).

And

> If downloading is time effective, it can allow for faster access to information without having to track down books or hardcopy resources. The information will be up-to-date. It can be accessed from the patient's bedside for teaching and learning based on specific questions by the patient.

The other main benefit cited by our respondents was the use of mobile devices to improve communications between faculty and students who are off campus in practice placements and, therefore, to afford students greater access to their instructors. In this regard, one instructor noted that mobile devices could provide:

> Instant communication with students (i.e., texting/emails) - texting re "checking in" with students who are in indirect supervision (i.e., community placements) - using blackboard to send messages to students, receive documents from them (i.e., domains of practice) -use of nursing resource software to support myself and students in the practice setting (i.e., medication software, psychomotor skills, nursing assessment) -access best evidence to support practice (i.e., databases to search for information related to practice).

And a BSN student noted that mobile devices could provide "support from teachers, we have two towns primarily that we are sent to for placements and our instructors may not be immediately available. We could get quick responses and support from them if we had communication on these devices."

But our respondents also reported on barriers to the use of mobile devices in their teaching and learning. The most widely barrier discussed was the cost of both mobile devices and of wireless connectivity and who should pay for it. For instance, one BSN student asked "Not all people have these types of devices - they can be costly- with roaming time as well - will VIHA [Vancouver Island Health Authority, which runs the local hospitals and clinics] help in paying these bills? - will everyone be expected to have one?"

Our respondents also noted potential barriers pertaining to mobile use in the hospitals. One was a concern about infection control. One BSN faculty member commented that "[I] just wonder about infection control issues with these devices in the clinical setting, I can see this

as being an issue and also wonder if the cleaning products required by the agency would damage the devices?" Another concern was about current hospital policies related to mobile use. Another BSN faculty raised this issue as follows:

> Hmmmm... I think we need to inform and educate our colleagues in the agencies about the use of technology, that in fact using a cell phone near a cardiac monitor is not going to upset the monitor, nor will it upset communications, etc., within the hospital particularly. (I think this is true and I think there is a need to assure people that it is not going to get in the way of their practice...

And finally, while not a benefit or barrier per se, some faculty members discussed the overall need to adjust their teaching to take into account the mobile technology that their students are using in their daily lives. For instance, one BSN faculty member stated that:

> Students are very comfortable with technology these days and it is very much the norm at breaks and meal times to see them pull out their phones or mobile device and start to text and so forth. Many students have pointed out applications to me in these settings which they frequently use to support their learning, such as drug guides or "apps" which quickly remind them of vital sign norms and so forth. I want to understand them and be able to relate on their level. I want to be able to communicate with them and not appear that I don't know. I also want to maintain a sense of where they are at and without understanding the technology that they use and how this influences their learning, I would feel somewhat of a disconnect. I am not saying that it surpasses other ways of teaching, but for them it is the new 'normal' and I must adjust to it to help support/understand them as well as using other teaching/learning techniques.

3.4. Self-Efficacy

Most of our respondents reported owning a mobile device and most used it weekly at least to make telephone calls. How did such familiarity with mobile use translate into feelings of self-efficacy? The average mobile self-efficacy score (Table 6) was 68 out of total possible score of 100. However, these scores were negatively skewed indicating a tendency to higher scores with individual lower scores affecting the average. Therefore, the median score of 75 is likely more reflective of the group as a whole.

Table 6 Self-Efficacy Scores – Program Comparison (Faculty – Student combined)

Program	N	Mean	Median	Std. Dev.	Min	Max	Skew
BSN	83	72.16	79.00	24.523	5	100	-1.014
PN	38	58.92	64.50	29.357	0	100	-.624
Total	121	68.00	75.00	26.734	0	100	-.898

There was also a substantive difference between programs. BSN students and faculty had a mean score of over 13 points higher than PN program members (72.16 as opposed to 58.92). An analysis of variance (Table 7) showed the mean self–efficacy scores between programs to be statistically significant at the $\alpha \leq .01$ level.

Table 7. Self-Efficacy Scores by Program ANOVA results

		Sum of Squares	df	Mean Square	F	Sig.
SE Score * Program	Between Groups (Combined)	4566.273	1	4566.273	6.692	.011
	Within Groups	81197.727	119	682.334		
	Total	85764.000	120			

Table 8 compares the mean mobile self-efficacy scores by faculty and student. The mean student self-efficacy scores were higher than those of the faculty, but faculty median scores were higher, indicating that the faculty means were likely affected by an outlier. However, an ANOVA showed no statistically significant differences between the self-efficacy scores of these two groups.

Table 8. Self-Efficacy Scores - Faculty-Student Comparison

Faculty-Student	N	Mean	Median	Std. Dev.	Min	Max	Skew
Faculty	17	62.12	80.00	35.173	0	100	-.635
Student	104	68.96	74.50	25.176	0	100	-.913
Total	121	68.00	75.00	26.734	0	100	-.898

A Pearson's r correlation between age and self-efficacy was -0.145. While this mild negative association indicated self-efficacy scores tended to be higher on average for the lower age groups, this relationship was not statistically significant.

4. CONCLUSION

M-learning has the potential to bring the instructor, peers and resources together virtually at the point-of-care to support the students' safety and evidence-informed practice. This study assessed the current use of mobile technology by faculty and students in nursing education and investigated their predisposition to use this new technology in their teaching and learning.

Our first research question asked in what ways faculty and students were currently using personal mobile devices in their teaching and learning. The results of the demographics portion of our survey revealed that most respondents owned mobile devices and that nearly half (46%) owned smart phones or 3G devices. Furthermore, the ownership of these more sophisticated mobiles was spread fairly evenly across the groups and all ages. While our respondents' used their mobiles weekly and predominantly for communications (cell phone, texting and email), they also used them regularly for a range of other activities, including web browsing, photography, word processing and health applications. More importantly, nearly two thirds (65%) of the time, our respondents used their mobiles in their teaching and learning. This data alone indicates that our respondents were not only predisposed to use mobile devices in nursing education, they have already begun to do so.

Our second research question queried how our respondents foresaw using mobile devices in their teaching and learning in the future? This question was addressed most specifically by our respondents' replies to the open-ended question asking their views about the potential uses of these technologies to support teaching and learning in the practice area. They pointed out both benefits and barriers to such use. Among the benefits were just in time access to current, professional information at the point of care and improved communications between students and faculty, especially while students are out in clinical practice placements. Among the barriers to use of mobile devices were the cost of purchasing a device and for wireless connectivity, as well as issues of infection control and adhering to current hospital policies.

And finally, we also asked to what degree is the level of mobile self-efficacy of nursing faculty and students related to their potential use of m-technology in teaching and learning? Self-efficacy refers to individuals' personal beliefs that they are capable of learning and performing particular behaviors. The stronger the sense of personal efficacy they possess, the greater will be their perseverance and the higher the likelihood that they will perform the chosen activity successfully (Bandura, 1997; Compeau & Higgins, 1995). The mean self-efficacy score for our respondents was 75, a rating that reflects a high level of confidence in their ability to use mobile technology.

These self-efficacy levels, however, were significantly different between program groups with BSN students and faculty an average difference of 13 points higher than PN students and faculty. Since, the PN program is a one year certificate, while the BSN is a four year, baccalaureate, program, it is possible that higher levels of education and experience could contribute strongly to an individual's sense of mobile self-efficacy in learning contexts. No other comparisons resulted in significant differences. There was no discernible difference in mobile self-efficacy between faculty and students. While there was a slight relationship between age and self-efficacy in favor of younger respondents, this correlation was not statistically significant. It appears then that nursing faculty and students are familiar with the use of mobile technology and a substantial proportion is very comfortable using the various functionalities these devices afford. Therefore, it is reasonable to conclude that nursing students and faculty, as represented by our respondents, are well prepared and strongly motivated to engage in mobile learning.

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APPENDIX A: MOBILE SELF-EFFICACY SCALE QUESTIONS

	If I had a mobile device such as a smart phone or 3G phone (e.g., iPhone), I could use it in my Nursing instruction…
Q1	...if there was no one around to tell me what to do as I go.
Q2	...even if I had never used a device like it before.
Q3	...if I had only the device manual for reference.
Q4	...if I had seen someone else using it before trying it myself.
Q5	...if I could call someone for help if I got stuck.
Q6	...if someone else had helped me get started.
Q7	...if I had a lot of time to complete the task for which the device was provided.
Q8	...if I had just the built-in help facility for assistance.
Q9	...if someone showed me how to do it first.
Q10	…if I had used similar devices before this one to do the same task.