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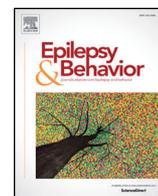
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## Q1 Self-management for people with poorly controlled epilepsy: 2 Participants' views of the UK Self-Management in epILEpsy 3 (SMILE) program

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## ABSTRACT

**Background:** Epilepsy is a long term condition that requires self management, but currently, there is no well evaluated epilepsy self education or self management intervention in the United Kingdom (UK).

**Aim:** The aim of this study was to examine the views and experiences of the first participants of the Self Management in epILEpsy UK (SMILE UK) program to assist the development of a full trial.

**Method:** In depth semistructured interviews and group discussions were conducted with 10 people with poorly controlled epilepsy to explore their views and experiences of the self management program. Interviews were audio recorded, transcribed, and analyzed thematically.

**Results:** All participants viewed the program positively. Three themes emerged: i) peer support was experienced through knowledge sharing, disclosure of experiences, and exchange of contact details; ii) participants felt better equipped to enter discussions with doctors and other health care professionals about their condition; and iii) participants reported an improvement in their personal life through increased confidence to live with epilepsy and acceptance of their diagnosis.

**Conclusion:** A brief group self management intervention increased knowledge and confidence in managing epilepsy.

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## 1. Introduction

One of the greatest challenges to global health and social care organizations is the increasing prevalence of long term conditions and multiple morbidity [1]. The associated health care costs are considerable: estimates for the proportion of total national health expenditure in the United States associated with chronic disease is 75% [2]. In England, 80% of general practitioner consultations are by people with chronic disease [3]. The concern to both reduce costs and increase quality of life has led to an increased focus on self care strategies as a central component of the management of long term conditions with the aim of enhancing patients' knowledge, skills, and confidence to manage their own health [4]. Variations exist in the literature for defining self management, but

in its simplest form, it describes a patient taking an active role in his or her treatment [5].

Epilepsy is a long term condition that requires individuals to learn to manage their own condition, including identifying and managing seizure triggers, implementing strategies to comply with multiple antiepileptic drugs, implementing precautions to minimize seizure related risks, and educating others what to do during and following a seizure. A consistent finding is that many people with epilepsy would like to receive better provision of information about how to live with and manage their condition [6–10]. However, currently, there is no well evaluated self education or self management intervention in the United Kingdom (UK) for epilepsy, despite this being a relatively common condition with over 600,000 people with epilepsy in the UK and estimates that countries in Europe spend around 1% of their national health care expenditure on epilepsy [11].

Cochrane reviews [12,13] have found four epilepsy specific educational interventions, including the Modular Service Package Epilepsy (MOSES) program, developed in Germany and offered as part of routine epilepsy care in the German health care system [14]. The MOSES program can be offered as a two day educational program for groups of between eight and 12 individuals, and relatives/carers may attend. It is suitable for application in both inpatient and outpatient settings for people with epilepsy aged 16 years and older without a learning

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disability. The program is designed to foster interaction between those attending as well as with the course leaders and to encourage processing of material at an emotional and cognitive level as well as facilitating a change in behavior. The MOSES program has demonstrable benefits including improved knowledge about epilepsy, better seizure control and coping, and a greater tolerance of and fewer reported side effects of antiepileptic drugs [14]. We contend that MOSES shows promise for transfer to the UK setting [15].

In preparation for trialing MOSES in the UK, we took advantage of developmental work [16] to adapt it to the UK setting and build workforce capacity through the development of high quality program Facilitators. The materials and course content were finalized as the Self Management in ePILEpsy (SMILE (UK)) program in May 2013, comprising nine modules: living with epilepsy, people with epilepsy, basic knowledge, diagnosis, treatment, self control, prognosis, personal and social life, and networking. These topics are delivered using a range of teaching techniques that encourage group participation and are also based around some factual information: the use of statement scales (participants are each invited to identify where on a scale they view themselves in response to a statement such as “Epilepsy makes me feel lonely”), brainstorming by the group, the provision of ideas used for mind mapping, and conveying some information via factual slides. Prior to undertaking a randomized controlled trial of SMILE (UK) [15] with patients with poorly controlled epilepsy, we carried out pilot work including the qualitative exploration of pilot patients' personal views and experiences of the program. It is these views and experiences of the first UK recipients of the program that we report here.

## 2. Method

### 2.1. SMILE (UK) program

Two pilot courses were delivered. A course comprised two days each 09:30 to 17:00 scheduled as four main half day sessions with a lunch break and two further breaks for refreshments per day. Staff with expertise in aspects of epilepsy management were recruited by LR to act as course Facilitators. Each pilot course was delivered by two Facilitators who were an epilepsy nurse specialist (ENS) and an EEG technician. The venue was the education center of a large teaching hospital that was familiar to the participants through their treatment and adjacent to the emergency department. Each participant was given a copy of the program workbook, with chapters corresponding to the nine modules that formed part of SMILE (UK). Each chapter contained some factual information that served to underpin the more interactional nature of the delivered sessions, with dedicated spaces for participants to write notes or complete exercises, as well as bullet point summaries of each of the topics covered during the sessions.

### 2.2. Participants

Twenty two people were recruited to the pilot study through an advertisement placed on the website and social media associated with Epilepsy Action (March 2013–May 2013). Nine were lost to recruitment (unable to contact, health reasons, work commitments). Thirteen adults with a formal diagnosis of epilepsy, being prescribed antiepileptic medication, who had experienced more than one seizure in the previous 12 months participated in one of two pilot SMILE programs and, additionally, were invited to give their views and experiences. Two participants did not complete the course. One participant required emergency department treatment for an injury sustained during a seizure and did not attend one afternoon session, and the second participant left an hour early on one of the days due to seizure related tiredness. Three participants declined to participate in these interviews.

The views and experiences of 10 participants in the SMILE (UK) program were collected pragmatically through group interviews with one group of three participants and semistructured interviews with seven

participants, of which four were conducted face to face and two as telephone interviews, in response to individual preference. One individual responded via email. Individual interviews typically lasted between 20 and 30 min, and the group session took 60 min. All data collection occurred within one month of completing the SMILE (UK) course.

### 2.3. Interview topic guide

A topic guide was developed by the research team in consultation with colleagues at Epilepsy Action. The topic guide covered participants' reasons for volunteering, views of the course materials and style of the course, and perceived usefulness of the program (Table 1). AL conducted the interviews and was not involved in the implementation of the pilot courses to minimize data contamination.

### 2.4. Data analysis

Interviews and discussions were audio recorded and transcribed verbatim. Each transcript was checked and read in full by AL, with a sample read by MM and LR, to gain an overall perspective of the data and to allow for a comparison of interpretations, thereby enhancing reflexivity. The topic guide prompts were flexible, allowing for revision of prompts during interviewing phase if necessary. The formal process of data analysis began with reading the transcripts and making notes of participants' perceptions and explanations in the margins. Data were analyzed iteratively, going back and forth between data and an emerging structure of 'ground up' themes related to the study objectives. The qualitative data analysis software NVivo 9 (QSR International) was used to systematically code the data and assist analysis. Emerging findings and interpretations were discussed during group meetings.

The National Research Ethics Committee London (Fulham) approved the study (12/LO/1962). Informed consent was obtained from all participants.

## 3. Findings

### 3.1. Participants' characteristics

The participants' mean age was 37 years (SD 13.1), mean years living with epilepsy was 25 years (SD 17.5), and 60% were female (Table 2).

**Table 1**

Topic guide.	t1.1 t1.2
Following brief introduction and reappraisal of consent and questions about participants' circumstances (age, living arrangements, educational achievement), they were asked about their views and experience of taking part in the pilot SMILE (UK) program. The main prompts (in italics) are given below:	t1.3 t1.4 t1.5 t1.6
Why did you decide to take part in the SMILE pilot?	t1.7
<i>Have you been involved in anything like this before?</i>	t1.8
<i>Was it because it was something you had been looking for already, or was it the idea of being part of something new in epilepsy treatment, for example?</i>	t1.9 t1.10
What did you think of the content of material that was delivered during the two days?	t1.11 t1.12
<i>Topics covered? Were any that were particularly useful? Any that you found you didn't particularly like?</i>	t1.13 t1.14
<i>How did you find the way in which information was delivered? Was it easy to understand or a bit difficult?</i>	t1.15 t1.16
How did you find learning with others in a group?	t1.17
<i>Were there any advantages to this for you? Were there any disadvantages for you?</i>	t1.18
<i>Did you find it easy to participate and contribute or was this difficult?</i>	t1.19
What did you think of the different teaching methods used? (Statements, mind maps, brainstorming and information slides)	t1.20 t1.21
<i>Did you like the different teaching methods used during the course or did you find them confusing?</i>	t1.22 t1.23
How useful do you consider the course to be for the future?	t1.24
<i>Do you think you'll be able to use anything you experienced on SMILE again? Useful to use with others in your life?</i>	t1.25 t1.26

**Table 2**

Demographics of people with epilepsy participating in SMILE (UK) pilot.

ID	Gender	Age (years)	Years with epilepsy	Type of epilepsy (self-report)	Education	In employment
1	F	33	13	Occipital lobe	Postgraduate	No
2	M	21	21	Temporal lobe	Secondary school	No
3	M	48	47	Complex partial	Secondary school	No
4	F	60	44	Temporal lobe	Undergraduate	No
5	M	53	52	Frontal lobe	Secondary school	Yes
6	F	40	34	Complex partial	Undergraduate	No
7	F	32	9	Complex partial	Secondary school	Yes
8	M	32	8	Frontal lobe	Undergraduate	No
9	F	21	15	Complex partial	Secondary school	No
10	F	29	8	Temporal lobe	Undergraduate	Yes

The most frequent type of epilepsy self reported by participants was temporal lobe epilepsy. Only three participants were in formal employment, all on a full time basis. All participants had achieved GCSE level qualification at a secondary school, four had obtained an undergraduate degree, and one obtained a postgraduate degree.

### 3.2. Smile (UK): participants' views

Participants reported a variety of reasons for volunteering to take part in the pilot SMILE program. For one, it was part of taking control of her life and fitted in with her self management decision making; for four participants, taking part was for general interest, in particular meeting others with epilepsy; two participants took part because the research was developing a new treatment, including one individual who saw it as “giving back” to the medical community.

Of the nine topics covered during the course, four were highlighted as being particularly useful: Basic Knowledge, a chapter which covers common questions about epilepsy, including the different causes of epilepsy, the development of seizures, and how to identify different types of seizures; Diagnosis, a chapter which covers the most important investigations for the diagnosis of epilepsy, including how to accurately observe and describe seizures and document them, and to assess correctly the risks of different investigations; Self control, a chapter which covers opportunities to influence how and when seizures occur, including avoiding seizure triggers and learning how to interrupt seizures; and Personal and Social Life, a chapter which covers the psychosocial aspects of epilepsy, including how to improve self esteem and supporting independent living. No topic was identified as being redundant. The main areas of criticism about the program were about duration and infrequent use of the workbook during classroom based activities: first, participants perceived the course to be intensive over two days and the preference would have been for the course to have been scheduled over three days; and second, participants would have appreciated greater reference to the program workbook by the Facilitators, including more encouragement for participants to write in it and make individualized notes.

When participants described their experiences more deeply, three themes began to emerge: the group experience, application of new knowledge, and personal life improvement.

#### 3.2.1. Peer support

A key motivating factor in participating in the SMILE (UK) program was meeting others with epilepsy. This was especially demonstrated by the fact that during the second day for each pilot course, participants requested the exchange of personal details and a forum to be set up for them, e.g., Facebook page, email mailing list. Eight respondents saw other group members as having become experts in epilepsy through experience, thus, allowing their own personal knowledge to be increased

about shared types of epilepsy. In particular, participants commented on the value of exchanging personal experiences of treatments for epilepsy, especially drugs and surgery. There was a feeling that decision making was improved by interacting with people who had already made a similar decision and who were living with that decision:

“I was very keen to meet other people with epilepsy and learn new information...it was really interesting to see a variety of perspectives based on personal experiences...[The group discussed]...different treatments they have experienced, and talk about how the drugs they have tried and share different views on how the drug worked for them differently... it was also good to speak to people who have had other treatments such as surgery or VNS” (participant 9).

“I have met with a doctor here about surgery and also it was good to meet somebody else [on the course] who has been through surgery and to be able to talk about it, how it made her feel” (participant 7).

The three participants who had been living with epilepsy for more than 34 years were able to share their knowledge about different situations and experiences, which was of particular importance for those with a recent diagnosis of epilepsy who were just starting on the journey of acceptance:

“I've caught up with being alright like they're just starting off with square one, down on the bottom” (participant 5).

Participant 6 corroborated this by describing the different stages of a process of having epilepsy. She placed it in the context that she had been living with epilepsy since she was seven years old, yet someone else in the group had only been diagnosed at the age of 20, which was very recent:

“So we're all in a different stage of the epilepsy process and it's learning to live with epilepsy, the initial shock, finding a voice, positive steps about epilepsy. Some of these other people might just be at an initial staged, still in shock, still processing the fact that they have epilepsy and so to put people with their experiences in the course, we could influence from our experiences” (participant 6).

It was acknowledged that as they were all in the same situation of having epilepsy, this made the group situation much easier:

“Normally, I'd be a bit self conscious about these groups but once I got used to it, knowing that everyone's like, the same, as me and there's like a big understanding amongst the group and become friends and stuff, it was actually pretty good” (participant 2).

However, a barrier to a successful group setting sometimes arose through “one upmanship”, a dominant individual, or nervousness

- 257 about participating in front of strangers. One respondent also noted  
258 how the extreme positive experiences could sometimes impact nega  
259 tively on others in the group:
- 260 “Because you were very positive about your epilepsy and that  
261 narked somebody at the end. They were narked with you about be  
262 ing so positive” (participant 6).
- 263  
264 She also reflected on the potential problem of one upmanship and  
265 although she had not experienced it in her group, she explained that  
266 she had kept quiet deliberately for some of the course to avoid this. As  
267 she explained:
- 268 “Sometimes people with epilepsy have to go one worse than the per  
269 son next to them. In some sort of perverse way, it turns out to be a  
270 competition for who...who's worse and who's undergone the worst  
271 experience...” (participant 6).
- 272  
273 Finally, it was noted by participant 3 that the danger of a group set  
274 ting was that an individual could dominate discussions and cause diffi  
275 culties within the group:
- 276 “Some of the topics [in the programme] weren't touch because indi  
277 viduals dominated the group and so the discussion went off on a  
278 side track...so I think being aware of one individual not being able  
279 to dominate the whole thing” (participant 3).
- 280
- 281 *3.2.2. Applying new knowledge and learning*
- 282 This was facilitated through the course workbook, which was con  
283 sidered by all to be essential as a reference resource for the future and  
284 a way of making the content portable for them as well as allowing  
285 others access the new information:
- 286 “It lives kind of by my bed...everything I want is in one place, which  
287 is nice... My Mum loved the book, because obviously she can read it  
288 as well” (participant 10).
- 289
- 290 “I can't stop carrying it around. Before I used to carry around my iPad  
291 all the time and bring that out all the time. But this is what I have to  
292 read all the time” (participant 7).
- 293  
294 Two types of explanation emerged of how participants would apply  
295 their new learning. One related to being able to offer more to a doctor or  
296 nurse during clinic appointments through more detailed answers,  
297 which they felt would then produce better answers from the health pro  
298 fessional. As participant 2 explained:
- 299 “When I see epilepsy nurses and neurologist and consultants in the  
300 future, instead of just hoping to give them small answers...you can  
301 give them more detailed and structured answers. And you'll proba  
302 bly get a better sort of answer out of the person you're speaking  
303 to.” (participant 2).
- 304  
305 Similarly, participant 4 saw her increased knowledge as empowering  
306 and put her on a level footing with her doctor:
- 307 “It's empowering you when you got to see the doctor to be more  
308 two way about the discussion” (participant 4).
- 309  
310 Participant 3 also spoke of being more informed and able to talk and  
311 have an opinion about a course of treatment:
- 312 “It's armed me with more information and sort of questions that I  
313 can ask and talk to other people...it's encouraging to go and ask  
314 questions rather than just being told and saying to your doctor well
- have you thought of doing this, can I do this or can I try this new  
medication? Rather than just relying on the doctors. It's inspired  
me in that respect to question and not actually just to accept what  
the doctor says” (participant 3).
- 315  
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320 For another participant (participant 7), it was a way to help a general  
321 practitioner understand her condition. She described a “blind leading  
322 the blind” relationship with her GP, and her increased SMILE (UK)  
323 knowledge would help them both through discussions about her epi  
324 lepsy and strengthen their relationship:
- “I think it will [be useful for interacting with health professionals].  
With my GP as well....because I don't feel my GP, I don't think he  
knows...I think he feels I don't know enough about epilepsy and I  
don't feel he knows enough either so we're both in the same boat  
in a way so just to talk to him, so during my appointments with  
him, talk to him about it” (participant 7).
- 325  
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329  
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331  
332 The second response to the learning and understanding gained  
333 through SMILE (UK) was through the education of family members.  
334 Some described their relatives as benefiting from the workbook, while  
335 the husband of one participant accompanied her to the hospital for the  
336 course and stayed for the first day because he felt that he also had a  
337 need to increase his knowledge and understanding. The same partici  
338 pant's family believed that her epilepsy was caused by evil spirits and  
339 she appreciated having information she could share with them to educate  
340 them better:
- “And it was also good for my partner [attended day 1]. He actually,  
because he said he needed to learn a bit more” (participant 7).
- 341  
342  
343  
344 “With my family. Like, to inform them more about it. Because a lot  
345 of them feel like, around the religion part, because they feel it's  
346 the evil spirits but they need to know a bit more about it”  
347 (participant 7).
- 348
- 349 *3.2.3. Improving the person's personal life*
- 350 Some participants described the SMILE (UK) training as leading to an  
351 improvement in their life through increasing their acceptance of the  
352 diagnosis:
- “Because I know a bit more and before [the course] it was actually  
having acceptance of epilepsy [that was a problem]. I would say  
I'm, by percentage, I'm like on 80% now...and it was meeting other  
people as well and being able to talk about it.” (participant 7).
- 353  
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356  
357  
358 Three participants spoke of their increased confidence following  
359 their interaction with others with epilepsy, with one participant feeling  
360 “proud”, suggesting the potential for a protective effect against per  
361 ceived stigma.
- “I came away from this course feeling more confident and proud”  
(participant 9).
- 362  
363  
364  
365 “Oh the confidence to talk, yeah. Because it has given me more, more  
366 confidence, because I know a little bit more ...and it was meeting  
367 other people as well and being able to talk about it” (participant 7).
- 368  
369 “I think you've probably re stimulated me to organise my life! I don't  
370 know that I will but it at least had that effect” (participant 4).
- 371  
372 One participant seemed to suggest that through the discussions with  
373 peers and guidance by the pilot course leader, he began to reflect on his

374 personal coping mechanisms and that perhaps, he judges himself too  
375 harshly in his day to day life:

376 "It does make you think though, maybe I'm, you know, I'm too mis-  
377 erable, am I a bit harsh with myself?" (participant 8).  
378

#### 379 4. Discussion

380 Epilepsy is a common long term condition requiring a high level of  
381 daily self management, yet no self management program has yet been  
382 tested in the UK. We present here the experiences and views of the first  
383 UK patients with epilepsy to participate in a pilot of a self management  
384 program, SMILE (UK), prior to a formal randomized controlled trial  
385 [15,17]. Broadly speaking, participants enjoyed the program and the asso-  
386 ciated manual, supporting previous work that found universal popularity  
387 for a self management intervention [18] and the generally positive re-  
388 sponses to MOSES in Germany [14]. Importantly, three key findings  
389 emerged about program experiences: first, participants described power-  
390 ful peer support during the program, experienced through the sharing of  
391 knowledge, disclosure of experiences, and exchange of contact details  
392 between peers independently of the program; second, participants felt  
393 better equipped to enter discussions with doctors and other health care  
394 professionals about their condition following the program; and finally,  
395 participants experienced an improvement in their personal life through  
396 increased confidence to live with epilepsy and acceptance of their  
397 diagnosis.

398 The finding that the group setting and peer support through the  
399 SMILE (UK) program was perceived to be a positive experience echoes  
400 other self management studies [19–24]. For example, Skinner et al.  
401 [20] demonstrated that interaction between participants during a self  
402 management program for diabetes mellitus changed their illness percep-  
403 tion, with the less facilitators talked (and thus, the more group partici-  
404 pants interact) having a positive effect on change in illness perception.  
405 An explanation of the effect of peer support may be found in Social  
406 Learning Theory; a Cochrane review [25] of lay educator delivered self  
407 management programs for people with chronic disease considered  
408 peers to be role models, based on the modeling construct in Bandura's  
409 Social Learning Theory [26]. This construct indicates that learning  
410 through the observation of others is a particularly important influence  
411 on behavior and there needs to be a quality that is desirable to be imitat-  
412 ed. Thus, someone dealing particularly well with their epilepsy was a po-  
413 tential role model to others in the group; this opportunity for learning  
414 would not have come about through didactic learning styles or indeed  
415 from health professionals' expertise. Indeed, to illustrate this, partici-  
416 pants spoke strongly of the benefit of meeting someone with epilepsy  
417 who had made the decision to undertake a surgical treatment about  
418 which they had been grappling to make a decision. Patients can see  
419 how others manage their disease, learning from their experiences, and  
420 thus, work to improve their own health status [27]. Particular aspects  
421 of the program delivery facilitated the peer support findings reported  
422 here; for example, the timetable for the program included three sched-  
423 uled breaks per day, meaning participants could informally interact  
424 with individuals from whom they wanted to gather specific or intimate  
425 information. Facilitators also could offer more tailored advice during  
426 these breaks. The teaching methods also facilitated role modeling, with  
427 participants being invited to enact situations personally experienced,  
428 e.g., being found postseizure.

429 The aim of self management approaches was to have well informed  
430 patients, who are able to make effective decisions and choices them-  
431 selves about their long term condition; this is referred to as increased  
432 health literacy [28]. Definitions of health literacy initially mostly cen-  
433 tered on the patient's ability to understand health information, although  
434 recent conceptualizations include the influences of social determinants  
435 such as peer groups, mass media, and culture [29]. Low health literacy is  
436 related to poor self management [30], low involvement in consultations

437 with health professionals and decision making [31], higher emergency  
438 department use [32], and increased hospitalization [33]. Health literacy  
439 seems to focus on knowledge, but perhaps, what is also important and  
440 gained from self management groups is confidence, self esteem, and  
441 practical guidance. Certainly, our pilot findings suggest that there is an  
442 effect of empowerment for these participants that might enable more  
443 equal engagement with health professionals. The teaching methods  
444 employed by the program encourage participation and build up during  
445 the day, from speaking in pairs to participants standing in front of the  
446 group to indicate on a diagram their personal feelings about their condi-  
447 tion, e.g., a response to the statement "epilepsy makes me feel sad". The  
448 building up of methods develops the confidence of participants to con-  
449 tribute to the group and to learn to communicate their experiences or  
450 feelings. Furthermore, the program offers sustained interaction with  
451 specialist health professionals, where some individuals may only see  
452 an epilepsy specialist annually, depending on their health service provi-  
453 sion. Having the program facilitated by experienced epilepsy practi-  
454 tioners gives participants the opportunity to develop strategies to  
455 communicate with potentially unfamiliar health professionals.

456 Finally, the benefits of collecting qualitative data during a trial are  
457 considerable. At this pilot stage, it was possible to further develop the  
458 skills of newly trained Facilitators by, for example, disseminating partic-  
459 ipant responses about the perceived competitiveness within the groups  
460 that might be present among people living with epilepsy, advising how  
461 to deal with the problems posed by a dominant member of a group, and  
462 instructing Facilitators to refer more explicitly to the workbook, encour-  
463 aging participants to annotate their workbook to tailor it and build per-  
464 sonally salient knowledge. By including qualitative methods at the pilot  
465 stage, the nested qualitative study for the main trial has been strength-  
466 ened through reflecting on important areas to include in future inter-  
467 view schedules.

#### 468 4.1. Limitations of the study

469 First, this is a small study of self selected volunteers from an  
470 epilepsy specific charity (Epilepsy Action), and the sample may have in-  
471 cluded highly motivated and interested people with epilepsy, for whom  
472 learning more about their condition was particularly important. Such  
473 self selection is a general feature of participation in self management  
474 programs [25]. Second, we report here the first patients receiving this  
475 intervention from health care professionals newly trained to deliver  
476 SMILE (UK), and it is possible that the course leaders' ability to deliver  
477 the intervention will increase with greater experience, thus, enhancing  
478 the benefits of SMILE (UK). In addition, we acknowledge that data were  
479 collected by different means and that in particular, group interviews  
480 might have inhibited participants' comments. However, it was felt that  
481 any effects of group interviews (e.g., not wanting to answer in front of  
482 others, reveal true feelings) would be limited through the fact that the  
483 interview groups were made up of participants who had attended the  
484 same pilot course together and there was already a sense of familiarity  
485 and trust between them. We did not, given the small sample size and  
486 the different means of data collection employed, seek to explore wheth-  
487 er the two pilot courses gave rise to different views by participants.

#### 488 5. Conclusions

489 Qualitative findings from modest pilot work suggest that people  
490 with poorly controlled epilepsy experience important peer support  
491 and increased self efficacy effects from the first UK delivery of the  
492 Self Management in epILEpsy (SMILE) program.

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## Disclosure

The authors have no conflict of interest to declare.

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