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Quiet time via transcendental meditation in secondary school pupils with special educational needs: effects on well-being and behaviour

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ABSTRACT

This paper describes effects on wellbeing as well as logistical difficulties of implementing regular Quiet Time (QT) via Transcendental Meditation (TM) among mainstream secondary school pupils with special educational needs, age 12-16 measured via a pilot Randomised Control Trial (RCT). Participants were recruited from three mainstream and one special school for children with autism and randomly allocated to QT (n = 17) or a Carry on as Usual (n = 16) control group. On average, the QT pupils attended only 2.7 meditation sessions per week, far fewer than the 10 sessions per week encouraged, despite TM being well liked. Pupils reported conflicting demands during TM time preventing regular attendance. Intention-to-treat analyses revealed no significant interactions between group and time. Within the QT group, higher attendance was associated with reductions in teacher-rated externalising difficulties, but these effects were mainly driven by the four pupils who attended more than 60% of the QT sessions. The main analysis revealed no significant effect of QT. The need for further feasibility work to establish and test strategies for promoting engagement with meditation strategies in busy secondary school environments is clear.

Keywords: quiet time intervention, transcendental meditation, secondary education, special educational needs
Introduction

Meditation in a variety of different forms has been practised for centuries and is commonly associated with different religious practices and belief systems. Many Eastern meditation practices relate to different yoga systems and the Vedic literature and tradition of India (Maharishi Mahesh Yogi 1990), as well as belief systems originating from China (e.g., Qigong (Klein et al. 2016; Yang et al. 2017)), along with traditions within Islam (Hosseini et al. 2016) and Buddhism, to which mindfulness and Zen are related (Lomas et al. 2017). Meditation is increasingly recommended by allopathic medicine to promote a healthier and more relaxing lifestyle, as an adjunct to mainstream medicine (Ee et al. 2017; Brinkhaus et al. 2017; Ee et al. 2017; Blödt et al., 2018). Regular relaxation times during the day are thought to help re-focus and de-escalate the build-up of stresses. However, there are relatively few studies systematically evaluating the psychological benefits of specific meditation techniques in different target groups (Rutledge et al., 2014; Wahbeh et al. 2017; Moss & Burton, 2004; Yang et al. 2017).

The prevalence of psychological distress among children with special educational needs is around 40%, compared to around 6% among children without special educational needs (Meltzer et al. 2003). The background to those on the special needs register in mainstream secondary schools varies from environmental adversity factors to specific learning difficulties or disabilities and neurodevelopmental problems like attention deficit disorder and autism spectrum conditions or any other child mental health diagnosis. Behavioural presentations range from challenging behaviour, anxiety / depression to self-harm in different degrees. Increased stress levels are a shared feature (Fazel et al. 2014; Vaz et al. 2014). Preventative school-based interventions exist, but are severely limited in terms of their impact and sustainability by a lack of attention to
implementation and coordination with other components of the school day (Meltzer et al., 2003).

Implementing health and wellbeing interventions in busy secondary schools are described as challenging by many (Fazel et al., 2014; Littlecott, Moore, & Murphy, 2018; Segrott, Rothwell, & Thomas, 2013), and often experienced as replacing academic learning targets in need of completion. However, rather than competing with educational tasks, one might argue that interventions improving health and wellbeing have the potential to calm the mind and create a sense of safety in which young people and staff can develop their creative potential, which could positively impact on academic performance (Lorenzi & White, 2019). In the new Welsh national curriculum, Curriculum for Wales, health and wellbeing constitute one of the core Areas of Learning and Experience (Welsh Government, 2020), and this implies that efforts to promote wellbeing in schools should be regarded as a central focus of school life, rather than a peripheral activity. Robust feasibility studies of any health and wellbeing intervention in school settings have the potential to provide useful insights into the interface between health, wellbeing and education, which can then be used to inform the design of future studies in this area in order to avoid known barriers.

Indeed, there is already some evidence that young people with special educational needs could gain particular benefits from meditation techniques. Meditation interventions already being studied in an education environment for the target population include Pranayama and Omkar (Krishnadasa, Shiva, Arunkumar, Anantharaya & Chatterjee (2018) among others (e.g. Fisher, 2006). There are also meditation interventions under investigation for parents and teachers of the target population, including mindfulness-based interventions (Benn, Akiva, Arel, & Roeser, 2012). However, supporting the expression of preference with regard to chosen
interventions is a core value of positive behaviour support and there is evidence to suggest that this, it itself, can reduce problem behaviour (Shogren, Faggella-Luby, Bae & Wehmeyer, 2004). In order to offer a choice of meditation techniques that supports the expression of preference, the research literature is clearly in need of further studies focused on a variety of meditation techniques that could potentially be beneficial for children with special educational needs.

Transcendental Meditation (TM) has been suggested as one meditation technique to help individuals easily reach a deep relaxing state, and this has been used with diverse populations, including even young children (Duraimani et al. 2015; Faber et al. 2017; Haaga et al. 2011; Nidich et al. 2009; Rasmussen et al. 2012; Tanner et al., 2009; Travis et al. 2011). The TM technique is a mental technique typically practised for 15–20 minutes, twice a day sitting comfortably (Haaga et al. 2011). TM practice involves a mantra, but unlike most mantra meditations, any possible meaning of the mantra is not part of TM practice. Rather, the individual is trained to appreciate the sound value of the mantra at more “refined levels” (Maharishi Mahesh Yogi 1997). Also, unlike most mantra meditations, the TM technique is not a process of concentration. Rather, TM practice is a process of “effortless transcending” (i.e., using the mantra as a vehicle to take attention from the ordinary thinking level to the least excited state of consciousness—consciousness without content). This state has been labelled pure consciousness (Duraimani et al. 2015; Maharishi Mahesh Yogi 1997). A range of sources provide discussion of the concept of effortless transcending (Braboszcz et al. 2017; Maharishi Mahesh Yogi 2001; Roth 2018; Travis & Parim 2017).

Studies on TM in adults are fairly extensive and have been shown to reduce blood-pressure, which led the US Federal Heart Association to recommend its use in conjunction with allopathic medication treatments (Jayadevappa et al., 2007; Nidich et
In education, feasibility studies have reported positive results (Travis et al. 2011) but to our knowledge no randomised control trials on TM with secondary school pupils registered with special educational needs have been published as yet in education. A recently finalised 2-year Quiet time / TM intervention project funded by the Europe Union reported preliminary positive results of phased TM intervention for students, teachers, and wider school community (EUROPE Project, n.d.). Participants were pupils, parents and teachers from colleges in Portugal, the Netherlands and Sweden. The aim was to reduce stress, violence and promoting social inclusion. A second European Union funded Quiet time/ TM project is currently running (FRIENDS Project, n.d.) where a secondary school in the United Kingdom also participates, along with schools in Portugal, Belgium and Italy.

Our own preliminary feasibility study, with 8 pupils registered with emotional and/or behavioural difficulties, showed a reduction in teacher-reported anxiety and ADHD symptoms after practising TM for 12 weeks. The present study builds on this work to test the hypothesis that a group randomly assigned to TM meditation, labelled ‘Quiet Time’, would show significant improvements in self-reported, parent-reported, and teacher-reported psychological functioning (both internalising and externalising characteristics), in comparison with a control group. Although many different paradigms for meditation interventions could potentially be used, including mindfulness, the simplicity and accessibility of the Quiet Time intervention for young people with special educational needs, combined with the extensive training work offered for teachers, was selected for this study.
Methods

Participants

Participants were aged 11 to 16 years and recruited from three mainstream schools (two mixed gender and one all girls), and one autism special needs unit (mixed gender) attached to an academy. These four schools came from a pool of fourteen secondary mainstream schools approached across the Worthing Child and Adolescent Mental Health Service catchment area (209,000 population). Eligibility criteria stated that students were on their respective school’s specialist register. This means they were in receipt of additional support by way of the School Action or School Action Plus programmes, or had a statutory statement of special educational needs.

Prior to implementing the intervention with the participating pupils, teachers at each participating school were given information about the methods of this study and were taught TM by a specialist TM trained teacher, using the same protocol outlined for participants. This systemic introduction of the research study through schools enabled for the intervention to be introduced to pupils within an accepting and supportive environment, in line with the approach to meditation suggested by TM. The trained teachers at each school practised the TM technique for 10-12 weeks prior to the implementation of the intervention with the participating pupils. This was designed to ensure they were solidly established in their practice by the time the pupils learned TM.

A target sample size of 15 in both the experimental group and the control group was identified for this pilot RCT using the formula for a statistical superiority design (Zhong 2009), based on the significant results observed in our preliminary feasibility study. Eligible students were provided with details of the study and intervention by way of small group presentations delivered by staff they knew within the school and a member of the research team. Contact details for the main point of contact within the
research team were provided so that students could ask additional questions before participating. Thirty-three young people provided written assent to participate and contact was made with their parents/carers to gain written informed consent. Participants were randomly allocated to the Quiet Time (QT) group (n = 17) or control group (n = 16) using an online random number generator. Ethical approval was obtained via the appropriate NHS review panel.

**QT Intervention**

The TM technique is ordinarily learned in a standardized seven-step course, including an introductory and preparatory lecture, personal interview, and four days of instruction of one hour each day. For this project the TM technique was introduced and taught across one individual session and two group sessions delivered over a period of two weeks. Once all participants in the QT group had received this brief TM training, quiet time was introduced for 10-15 minutes twice a day, during which time participants were encouraged to engage with the TM technique they had learned. A dedicated quiet area in the school was used for quiet time to minimise external distractions. QT was facilitated in each school by a TM trained member of teaching or learning support staff who knew the participants prior to the study. To support treatment fidelity, each school was given a detailed study protocol and access to a main point of contact within the research team to raise any queries about the study or intervention.

In addition, each participant’s individual QT practice was supported and consolidated through an individual meeting with a TM teacher every two weeks for the first 8 weeks and monthly thereafter. Schools were encouraged to slot the two 10-15-minutes quiet time sessions into their school day to fit in with their curriculum and existing timetable. One session was in the morning and one session was in the afternoon. School staff kept an attendance register of each quiet time session throughout
the study. Study delivery was monitored throughout the intervention phase with regular meetings between members of the research team. These meetings provided an important reflective space in which study activities were discussed and evaluated.

**Measures**

Validated questionnaires and a semi-structured interview were administered to participants at baseline (T1), at post-test after the intervention group had been practicing TM through QT sessions for twelve weeks (T2), and at follow-up eight weeks after the end of the intervention (T3).

The Teacher Report Form (TRF (Bordin et al. 2013)) for children aged 6-18 is completed by teachers or other school staff who are familiar with the child's functioning in school. It requests demographic information about the student, the respondent's role at the school and how long they have been there, how well the respondent knows the student, how much time the student spends in their class/service, and what class or service it is. Among other aspects of functioning, the TRF asks respondents to rate various items tapping into behavioural, emotional and social problems as 0 for *not true*, 1 for *somewhat or sometimes true* and 2 for *very true or often true* based on the preceding two months. We focused particularly on the internalising and externalising subscales, as well as the total problems score. All raw scores were transformed into T scores, with higher scores indicating more problems. The TRF is an extremely well-established, valid, and reliable clinical and research tool (Achenbach, 1991).

Parents completed the Parent/Carer version of the Strengths and Difficulties Questionnaire (Goodman, 1997). The Strengths and Difficulties Questionnaire (SDQ) is a valid and reliable brief behavioural screening questionnaire for children aged 3-16, suitable for use in research (Phillips et al., 2015). It asks respondents about 25 attributes, some positive and others negative. These are divided between five scales,
each with five items: 1) emotional symptoms, 2) conduct problems, 3) hyperactivity/inattention, 4) peer relationship problems, and 5) prosocial behaviour. Ratings were made from 0 (not true) to 2 (certainly true). Mean scores were calculated across the items within each scale, with higher scores indicating more negative characteristics for the first four scales and more positive characteristics for the final scale. The mean of the first four scale scores generated a total difficulties score (based on 20 items).

Participants completed the Paediatric Quality of Life (PedsQL) Questionnaire (Varni et al. 2011). This 23-item questionnaire has four scales designed to measure the core dimensions of health as delineated by the World Health Organization, as well as role (school) functioning. The four scales focus on physical health functioning (8 items), emotional functioning (5 items), social functioning (5 items), and school functioning (5 items). Items were rated from 0 (never a problem) to 4 (almost always a problem), and raw scores were reversed and transformed into percentage scores from 0 to 100, with higher scores indicating fewer problems (i.e., better quality of life). Scoring enables the calculation of a total scale score averaged across all 23 items, as well as a mean score for each subscale. The validity and reliability of the PedsQL have been established (Varni, Seid, Rode, 1999). Individual assistance was provided to ensure participants had read and understood the 0-4 rating scale and each item of the PedsQL.

Participants were also invited to take part in a semi-structured interview designed by us to evaluate participants’ personal views on their well-being over the past, present and coming year. Those in the QT group were asked in addition about their experience with QT (enjoyment, perceived benefits).

Analysis Plan
Descriptive statistics (averages and standard deviations) were used to explore attendance data. Participant interviews were transcribed and a thematic analysis was employed to draw out key themes. Themes were shared with school staff and students after the study had ended. Informal feedback from school staff was collected and summaries of any reflective conversations were written up and shared within research steering group meetings in order to gain an insight into the school perspective on the study. For each quantitative subscale score, a two-way mixed-design analysis of variance was conducted, with time (T1, T2, T3) as the within-subjects variable, and group (QT vs. control) as the between-subjects variable. For the QT group only, Pearson’s r and scatterplots were used to explore the presence and nature of any correlation between QT attendance and the changes in each quantitative item scores.

**Results**

**QT attendance**

There was evidence of substantial variability in the schools’ and individual pupils’ adherence to the meditation programme. Pupils were encouraged to attend two meditation sessions per school day (i.e. 10 sessions per school week, or 120 across the entire 12-week QT intervention). Participants attended on average 32.71 (SD = 31.48) meditation sessions in total, or 2.73 per week. However, this average masks considerable variation in the group: around a quarter of the individuals showed relatively high engagement (once or twice a day throughout), but others showed much more variable engagement, often with a drop-off after the first few weeks. Specifically, four individuals attended between 62.5% and 75% of possible QT sessions, whereas the thirteen other pupils attended only 30% or fewer of the sessions.
**Qualitative data from interviews with participants**

Analysis of the interviews with the pupils at both the post-test and follow-up time points showed that despite the low levels of engagement in the meditation sessions among some of the participants in the intervention condition, virtually all of those who were interviewed at the follow-up time points self-identified as having taken part in the meditation sessions at least to some extent: Fourteen of the 15 participants interviewed at T2 did so, and all 15 of those interviewed at T3 did so. Most, though not all, participants reported that they enjoyed the QT sessions, and some even continued to practise them at home:

- “I enjoyed them very much. They're quite fun and make me feel relaxed when I wake up. I use it quite often outside the school sessions” (girl, age 13)
- “I liked them quite a bit. It was always calming, very relaxed. The person that did it with us was very nice” (boy, age 15)
- “I enjoyed it a lot. I do it three times a day. I'm more relaxed, easier to get through the school day” (girl, age 14)

Moreover, when asked in the interviews at post-test (T2) to indicate how much they enjoyed the meditation sessions, the majority gave positive ratings. Ratings on a ten-point scale were significantly above the midpoint of the scale, mean (SD) = 6.65 (3.04). Not surprisingly, those with higher levels of attendance tended to rate the meditation sessions as more enjoyable, \( r(16) = .52, p = .038. \)

Many young people remarked that conflicts with other timetabled activities meant that it was difficult to attend sessions on a daily basis. Post-study informal interview discussions with teaching staff, which took place three months after the study ended, suggested that the QT might have been more easily introduced as part of the curriculum to be done in the classroom for whole year-groups rather than only targeting
those on the special needs register. It was pointed out that young people generally do not like to be singled out for interventions.

Changes in social, behavioural, and emotional functioning

Table 1 shows descriptive statistics for both the QT and control groups on all measures at each of the three time points. For each score, a two-way mixed-design analysis of variance was conducted, with time (T1, T2, T3) as the within-subjects variable, and group (QT vs. control) as the between-subjects variable. No significant effects were observed (all $p$’s > .05), with the exception of a significant main effect of time for both the teacher-reported internalising score, $F(2,56) = 6.95$, $p = .002$, partial $\eta^2 = .20$, and teacher-reported total problems score, $F(2,56) = 5.21$, $p = .008$, partial $\eta^2 = .16$. The tendency for these scores to decline from baseline to post-test and follow-up, however, was not different between the QT and control groups, as the interaction between time and condition was not significant.

Further analysis of intervention group data investigated associations between the level of QT attendance and the changes in scores from baseline to post-test (subtracting T1 from T2) or from baseline to follow-up (subtracting T1 from T3). The only significant correlations were between the level of attendance and the drop in teacher-reported externalising behaviour, from baseline to post-test, $r(15) = -.60$, $p = .018$, and from baseline to follow-up, $r(17) = -.60$, $p = .011$. Inspection of scatterplots showed that these effects were driven by reductions in teacher-reported externalising scores among the minority of four individuals who attended more than 60% of the possible QT sessions.
Summary of findings

Overall, levels of engagement with the intervention in the QT group were variable, as measured by attendance at sessions. Interviews conducted post-test indicated that most participants enjoyed the intervention, suggesting a level of acceptance. There was also a correlation between attendance and enjoyment of the intervention, with those who attended more sessions indicating greater enjoyment. The total number of problems and the extent to which participants internalised their problems, as reported by teachers, reduced over time for both groups, indicating some improvements in wellbeing through the school year. However, the lack of a Time x Group interaction effect clarifies that these observed improvements were not specific to the QT group. Nonetheless, four participants in the QT group attended more than half of the QT sessions on offer, and for these individuals, improvements in externalising behaviours were greater than for individuals who attended fewer sessions.

Discussion

Contrary to hypotheses, this study did not show a significant difference between the QT and control group with respect to changes in emotional and behavioural functioning. However, the study has shown that the logistics of implementing a relaxation intervention in a busy mainstream school environment were a challenge, and this appeared to affect attendance of the QT sessions, as measured by an attendance register and comments made by QT participants. This is consistent with previous research that found limitations in the impact and sustainability of preventative school-based interventions due to issues related to implementation and coordination (Meltzer et al. 2003).
As noted above, for a small number of participants who attended most of the QT sessions offered, an improvement was observed on teacher-reported externalising characteristics, consistent with the positive pattern we had observed in our initial feasibility work. However, the level of engagement with the meditation sessions in the group as a whole was not sufficient to constitute compelling evidence of positive effects.

In another non-randomised control feasibility study (Kuyken et al., 2013) with 522 young people aged 12-16 in mainstream secondary schools, mindfulness meditation was associated with greater wellbeing, less stress and less depressive symptoms. A positive relationship with the degree to which mindfulness was practised at 3 months follow-up was also noted. Overall, meta-analysis reviews of meditation interventions among young people show a paucity of robust RCT designs, making firm conclusions difficult despite the overall positive anticipations of benefits (Zhang et al. 2018).

The suggestion made by teachers to introduce QT via a whole-class approach, led by teaching staff, raises a number of interesting issues. The QT intervention would need to be organised within the curriculum, either in a dedicated timetable slot for the year group or by embedding them within the usual timetabled lessons. In addition, teaching staff need to feel comfortable with practising the meditation themselves and the present study’s requirements for teaching staff to have practised QT for 6 weeks might need to be extended to 3 months, in order to ensure the staff are confident about passing this technique confidently onto pupils and supporting them with it during the QT practice times.

It must be recognised that as this was a pilot RCT, the study was not fully powered to detect very small effects. Some tentative indications showed that the intervention could be linked with changes over time in some of the measures. A small
number of pupils who attended most of the meditation sessions showed improvements on teacher-rated externalising characteristics, consistent with the preliminary feasibility study we had previously conducted. However, we must stress that the magnitude of the effects in the QT group was not substantially greater than that of the effects observed in the control group. Additional limitations include sample size and length of follow up period. To address these issues, replications of this study or further studies of other meditation interventions in schools may benefit from recruiting more schools and from offering a second follow up, which would also support an analysis of whether any positive effects last over a longer time frame.

This study provides valuable insights into the challenges of coordinating a randomised controlled trial in a busy mainstream secondary school, where the intervention competes with other demands on time and commitment. Most pupils in the QT group did indicate they liked to meditate and even continued at home, but the research evidence is not sufficient for demonstrating positive effects of the QT intervention. The necessity to establish effective strategies promoting health and wellbeing interventions in busy school environments are now better recognised (Banerjee et al., 2016) and further initiatives are underway to understand the best approach (Hayes et al., 2019a, b). As noted earlier, some recent cross-European initiatives have enabled the successful implementation of Quiet Time, including work in Portuguese schools where a daily non-academic hour in the curriculum, to be used free of choice, was promoted by the government to achieve a better balance between health and wellbeing on the one hand, and academic achievements on the other (FRIENDS Project, n.d.). Further research to establish the viability of such implementation in UK schools, with robust research designs to establish causal impact, would be helpful for advancing our understanding and educational practice further.
Conclusion

The TM meditation was generally well liked and no adverse effects were reported. However, this study did not show a significant effect of QT on the outcome measures, relative to the control group. The study was substantially limited by difficulties in the regular implementation of the QT intervention among those on the special needs register. Regularity of meditation practice is an important factor in improvement of wellbeing and relaxation, underlying academic achievement and resilience. An approach that ensures all pupils in a year group, who are consenting to participate, are having dedicated time-slots for the meditation may be crucial for success, and this proposal needs to be evaluated in future research. In our view a longer period of TM practice (e.g., 3 or even 6 months) for teaching staff guiding the daily meditations before the pupils start, could help them feel more at ease and more familiar with the TM technique. Future studies could also work with all students in a given year group, rather than focusing only on selected individuals on the special needs register. Dedicated non-academic but relaxing activities such as reading could be given for those not consenting to participate, in the same classroom as for those who meditate. It would also be potentially valuable to include other experimental conditions involving different meditation intervention, such as mindfulness or guided meditation, in order to compare strengths and weaknesses of both approaches, perhaps with the prospect of combining them into one holistic model in the future.
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Table 1

Mean (SD) for each score at each time point, subdivided by condition (QT versus control)

<table>
<thead>
<tr>
<th>Measure</th>
<th>QT</th>
<th>Control</th>
<th>QT</th>
<th>Control</th>
<th>QT</th>
<th>Control</th>
<th>QT</th>
<th>Control</th>
<th>QT</th>
<th>Control</th>
<th>QT</th>
<th>Control</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>T1</td>
<td>T2</td>
<td>T3</td>
<td>T1</td>
<td>T2</td>
<td>T3</td>
<td>T1</td>
<td>T2</td>
<td>T3</td>
<td>T1</td>
<td>T2</td>
<td>T3</td>
</tr>
<tr>
<td>PQoL Total</td>
<td>64.00</td>
<td>63.93</td>
<td>64.50</td>
<td>66.92</td>
<td>66.38</td>
<td>69.98</td>
<td>64.00</td>
<td>63.93</td>
<td>64.50</td>
<td>66.92</td>
<td>66.38</td>
<td>69.98</td>
</tr>
<tr>
<td>PQoL Health</td>
<td>(15.06)</td>
<td>(17.71)</td>
<td>(14.70)</td>
<td>(16.79)</td>
<td>(17.62)</td>
<td>(15.10)</td>
<td>(15.06)</td>
<td>(17.71)</td>
<td>(14.70)</td>
<td>(16.79)</td>
<td>(17.62)</td>
<td>(15.10)</td>
</tr>
<tr>
<td>PQoL Emotional</td>
<td>75.74</td>
<td>70.51</td>
<td>72.59</td>
<td>73.44</td>
<td>71.25</td>
<td>75.24</td>
<td>75.74</td>
<td>70.51</td>
<td>72.59</td>
<td>73.44</td>
<td>71.25</td>
<td>75.24</td>
</tr>
<tr>
<td>PQoL School</td>
<td>49.41</td>
<td>55.00</td>
<td>56.33</td>
<td>55.31</td>
<td>56.67</td>
<td>58.85</td>
<td>49.41</td>
<td>55.00</td>
<td>56.33</td>
<td>55.31</td>
<td>56.67</td>
<td>58.85</td>
</tr>
<tr>
<td>SDQ Emotional</td>
<td>.46</td>
<td>.40</td>
<td>.40</td>
<td>.43</td>
<td>.38</td>
<td>.40</td>
<td>.46</td>
<td>.40</td>
<td>.40</td>
<td>.43</td>
<td>.38</td>
<td>.40</td>
</tr>
<tr>
<td>SDQ Conduct</td>
<td>(.39)</td>
<td>(.49)</td>
<td>(.40)</td>
<td>(.44)</td>
<td>(.42)</td>
<td>(.38)</td>
<td>(.39)</td>
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<td>(.40)</td>
<td>(.44)</td>
<td>(.42)</td>
<td>(.38)</td>
</tr>
<tr>
<td>SDQ Hyperact.</td>
<td>1.24</td>
<td>.96</td>
<td>.91</td>
<td>.88</td>
<td>.70</td>
<td>.78</td>
<td>1.24</td>
<td>.96</td>
<td>.91</td>
<td>.88</td>
<td>.70</td>
<td>.78</td>
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<tr>
<td>SDQ Peer Probs.</td>
<td>(.57)</td>
<td>(.80)</td>
<td>(.57)</td>
<td>(.58)</td>
<td>(.53)</td>
<td>(.71)</td>
<td>(.57)</td>
<td>(.80)</td>
<td>(.57)</td>
<td>(.58)</td>
<td>(.53)</td>
<td>(.71)</td>
</tr>
<tr>
<td>SDQ Prosocial</td>
<td>.95</td>
<td>.60</td>
<td>.71</td>
<td>.63</td>
<td>.58</td>
<td>.48</td>
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Note. PQoL = Paediatric Quality of Life scale (n ranged from 13 to 17); SDQ = Strengths and Difficulties Questionnaire (n ranged from 5 to 15); TRF = Teacher Report Form (n ranged from 15 to 17).
Figure 1. Meditation sessions attended per pupil (Quiet Time group)