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Solution-Focused Guided Imagery for a Golfer Experiencing the Yips: A Case Study

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ABSTRACT

A single-subject across situations design with repeated measures was used to test the efficacy of solution focused guided imagery with a 40 year old golfer suffering from a three year case of the “yips”. Yips are defined as jerks, tremors, or a freezing of the putting stroke which at the very least can add several strokes per round of golf. The current participant was experiencing an average of 9.2 yips per round during the baseline phase of the study and was able to decrease his number of yips to virtually zero, with an average rate of 0.2 yips per round during treatment.

Introduction

The sport of golf provides an excellent opportunity to test assumptions concerning motor control and performance due in part to the psychological and physiological demands upon the athlete. In particular, the skill of putting requires distance control, precise accuracy, and mental discipline for successful execution and is crucial for scoring because it accounts for 42% of all the strokes in golf (Palmer & Dobereiner, 1986). Unfortunately, a condition called the yips can interfere with the successful completion of the putting stroke. Researchers have defined the yips as an interruption in the putting stroke, usually occurring during short putts (Smith, et al., 2003).
This interruption emerges with symptoms such as jerks, tremors, or a freezing of the stroke (Smith, et al., 2000). Researchers have revealed support that yip-affected golfers have considerable playing experience, and are accomplished performers (McDaniel, Cummings, & Shain, 1989; Sachdev, 1992; Smith et al., 2000). Stories in golf also cite that the yips can emerge in other facets of the game ranging from chipping, bunker, and driving golf shots (Achenbach, 2004; Haney, 2004). Moreover, golfers who suffer from the yips appear to share some common elements and symptoms with other types of professionals who engage in activities requiring fine motor control including musicians, dentists, and surgeons (Smith et al., 2003).

The existing research suggests that the yips are a task-specific dystonia that is prompted and/or exacerbated by psychological factors (e.g. anxiety) (Smith et al., 2003). Dystonia is characterized by sustained involuntary muscle contractions, resulting in twisting, spasms, or flexing of a body part (Brin & Comella, 2004). That the yips are a form of dystonia is supported by the symptoms of a jerk, tremor, or freezing of the putting stroke (Smith et al., 2000; Smith et al., 2003). Additional evidence that the yips are a form of dystonia comes from studies showing that the condition is acquired over time and experienced during the performance of specific tasks. Clinical research has indicated that adult forms of dystonia begin after the age of 26 (Brin & Comella, 2004), which coincides with the emergence of the yips in middle-aged golfers (McDaniel et al., 1989; Sachdev, 1992; Smith et al., 2000; Smith et al., 2003.) Thus, the etiology of the yips as a neurological disorder is consistent with the late onset of physical symptoms detrimental to performance and the fact that the yips seem to be restricted to near experts with extensive playing experience.

Related research has revealed that anxiety is a contributing agent to focal dystonia and the yips (Byl, 2004; Cook, 1993; McDaniel et al., 1989; Sachdev, 1992; Smith et al., 2000; Smith et al., 2003). Psychological factors such as stress and anxiety have been shown to impact individuals who experience a focal hand dystonia (Grafman, Cohen, & Hallet, 1991; Kolle, 2000). For instance, Smith et al. (2000) found that yip-affected golfers experienced increased anxiety: (a) when leading a tournament, (b) attempting a difficult putt (e.g. downhill), (c) facing specific competitors, and (d) feeling the need to make the putt.

Research examining the influence of mental training and psychological interventions with yip-affected golfers suggests that symptoms common to a focal dystonia and the yips have the potential to be alleviated (Blundell, 1990; Byl & McKenzie, 2000). For instance, Byl and McKenzie examined treatments for twelve individuals suffering from a focal hand dystonia. Interventions consisted of sensory training and mental imagery designed to facilitate normal hand movements. Sensory training sessions were conducted two times per week and consisted of biofeedback of hand contractions until involuntary movements were controlled. Sensory training also consisted of identifying sensory stimuli, shapes, and objects. The mental imagery component consisted of the participants imaging successful, normal execution of target tasks. Results revealed that all but one participant achieved significant gains in sensory discrimination, physical performance, motor control, and functional independence. This study provides evidence that sensory training accompanied with mental imagery can improve those with focal hand dystonia. In conjunction with these results, Byl (2004) suggests that effective intervention strategies for people with a focal dystonia should incorporate minimizing stressors, enhancing self-esteem, and
building self-confidence.

In one of the few published records, Blundell (1990) reported a case study of an individual who experienced the yips. While this study is promising concerning a possible approach to help a golfer with the yips, it lacks any supporting data and therefore is not conclusive. The researcher identified the yips as an uncontrollable twitching of the right thumb and index finger during putting execution. Technical and psychological profiles of the golfer revealed that the yips were primarily due to psychological factors. Subsequent educational interventions included goal setting, breathing techniques, and additional relaxation strategies. Although no timetable for the interventions or recovery was presented, Blundell indicated that the three simultaneous interventions were lengthy in duration. Blundell also reported that this individual displayed no signs of the yips after numerous interventions. Various psychological techniques appeared to help relieve the golfer of the yips however, it is not precise regarding which technique was effective. There is a need for a more in-depth look at specific psychological interventions that can successfully reduce the yips.

Perhaps the most often used performance enhancement technique is mental imagery. Numerous studies have revealed that imagery has been used effectively by performers in various sports (Martin, Moritz, & Hall, 1999) and in a variety of ways (Rushall, 1988). A function of imagery can include motivational components for achieving goal behaviors and enhancing self-confidence (Callow, Hardy, & Hall, 1998). Martin and colleagues (1999) recommended that motivational imagery be used for competitive sport situations to increase one’s self-confidence and efficacy. Some researchers have suggested that imagery is most effective when it is used to address situational purposes specific to the respective sport or activity in question (Hall, Mack, Pavio, & Hausenblaus, 1998). Taken together, these results suggest that imagery may be a good fit for managing the yips.

Research also suggests that imagery is an effective intervention with golfers. For example, Cook, Horvath, and Connelly (1989) examined the effects of an imagery audiotape on putting performance. Two (imagery and non-imagery) groups of 15 skilled golfers (handicap < 10) completed a 9-hole putting course. Between putting sessions the imagery group listened to a five-minute tape that incorporated strategies such as relaxation, mental rehearsal, and goal-setting. Results revealed that the mental imagery group statistically improved three-foot putting scores across sessions while the non-imagery group did not. One possible explanation presented for the effectiveness of the imagery tape was that it reduced anxiety-provoking thoughts. Thus, it appears that imagery might serve as a useful technique for assisting golfers who experience the yips on short putts.

**Solution-Focused Guided Imagery**

One type of imagery is solution-focused guided imagery (SFGI) which is designed as a 15 question scripted guide for individuals to create vivid images of themselves thinking, feeling, and behaving in ways devoid of their problem (Sklare, Sabella, & Petrosko, 2003). According to Sklare (2005), the SFGI approach consists of five distinct steps: a) Clients establish a baseline rating (0-10) concerning the severity of the problem, b) Clients visualize themselves in situations when the problem does not occur and people who would notice, c) Clients notice and explore
exceptions to the problem, d) Clients imagine that a miracle occurred and solved their problem and describe the changes that would happen that would let them know the problem was solved, e) Clients write a message describing a behavioral goal, f) Clients rate the severity of the problem (0-10) after each session is concluded.

SFGI encompasses the goals of solution-focused brief counseling (SFBC) through the use of imagery (Sklare et al., 2003). SFBC is based on the premise that individuals are more likely to solve their problems if they focus on successes rather than their failures. Researchers suggest that SFBC can facilitate change in clients after just a few sessions, which makes this approach appealing to consultants (DeShazer, et al., 1986; Sklare, 1997).

Literature within the arena of sport has recently addressed using SFBC methods (Gutkind, 2004; Hoigaard & Johansen, 2004). Gutkind (2004) outlined using SFBC as an approach with an injured athlete. She suggests that SFBC is well-suited as a theoretical framework for injured athletes due to its emphasis on focusing on solutions and improving an athlete’s self-efficacy. Hoigaard & Johansen (2004) discussed using SFBC in the field of sport psychology and, in particular, with various types of athletes. They emphasize the benefit of SFBC as a means of emphasizing growth and improvement with an athlete. Together, these articles provide a strong rationale of the benefits of SFBC in sporting environments. However, neither of these articles provides empirical evidence supporting their claims. Thus, research within sport psychology may benefit by empirically testing the effectiveness of the basic tenets of SFBC.

While SFGI has shown to be effective in non-sport settings, (Sklare et al., 2003) to date, it has not been employed with athletes experiencing performance issues such as the yips. Therefore, the present study represents an exploratory attempt to determine the benefits of SFGI with a golfer who has been experiencing the yips. According to the sport literature (Martin et al., 1999; Callow et al., 1998), imagery has revealed to be effective for enhancing one’s self-confidence and improving performance. Also, since SFGI has yielded support for alleviating non sport related problems (Sklare et al., 2003), it was reasoned that the usage of SFGI may serve to diminish the debilitating effects of the yips.

**Method**

**Participants**

The participant was a 40 year old, white male, with a USGA handicap of 5. “A.J.” had played golf for approximately 10 years and demonstrated signs of the yips for approximately three years prior to the study. A.J. typically played a competitive round of golf at least twice a week and regularly wagered monetary bets with other players. The strategy A.J. had previously employed to alleviate the yips was a “claw” grip, which he found to be reasonably successful. The claw grip is designed for one hand to act as a stabilizing mechanism on the club to prevent twitching or flinching of the hands. However, A.J.’s overall putting accuracy had been declining, so he revisited his original grip and once again was at the mercy of the yips.

Prior to any data collection, Institutional Review Board (IRB) approval was obtained and A.J. signed an informed consent form. A.J. took part in this study with the understanding that he
was using SFGI, to help with the yips. The participant was also asked to continue to play golf in the same frequency and format. At the conclusion of the study, A.J. was asked to complete a questionnaire assessing his experience and effectiveness of using SFGI.

**Design**

A multiple-baseline across-situations (M-B A-S) design was employed in the current study and is characterized by examining data for the same behavior (yips) across different circumstances (greens) (Paniagua, 1990). The main objective of single-subject research is to investigate the relationship between treatment and behavioral change with individual participants (Berryman & Cooper, 1982). There are four common assumptions to which all single-subject research designs should contain (Holcombe, Wolery, & Gast, 1994). First, multiple data points are needed under various phases (e.g. baseline A and intervention B) in determining changes in performance or behavior. Second, each participant serves as their own control as participants’ performance is compared across baseline and intervention phases. Thus, stable baselines and non-overlapping data points are needed to assess individual behavioral changes and determine causality (Bryan, 1987). Stable baselines should be established through a minimum of three separate observations and consist of an upward or stable trend (Barlow & Hersen, 1984). Third, any single-subject design must account for repeated measures of a participant’s effect across conditions. Repeated measurement of the behavior or dependent variable is a prime source of identifying variability (Barlow & Hersen, 1984). Lastly, interventions can be compared on the same client and across different settings such as, in this case, different golf holes (Morgan & Morgan, 2001).

Due to the applied nature, data analysis of single-subject design research is conducted through visual inspection of the data (Barlow & Hersen, 1984). Effective interventions should reveal abrupt changes in means and/or slopes between phases as the intervention is introduced.

**Procedure**

The researcher met A.J. after placing an ad in a local newspaper seeking golfers who experienced the yips. During the initial meeting, A.J. discussed his experience with the yips. The participant’s self-reported symptoms of the yips included increased muscle tension in the hands, wrists, and arms. This tension would manifest itself in his right hand causing it to physically “turn over” and “flinch” during the execution of the putt. Occurrences of the yips were also context based, appearing during golf matches as opposed to practice sessions. The participant also reported that the yips were most prevalent on short putts of approximately four feet or closer, which coincides with the distance prevalently found in Smith et al. (2003). Thus, the operational definition of the yips consisted of any “flinch” of the hands during a putt from approximately four feet away and closer.

It was agreed that A.J. self-report the yips occurrences and a playing partner would record instances of the yips for interobserver agreement (IOA). Sufficient reliability measures such as IOA, help ensure treatment integrity, reliability, and validity (Hryciako & Martin, 1996).

Baseline data was collected during the first three rounds of golf to help ensure stable
measures. After the baseline phase, A.J. would meet with the researcher one day prior to play for five treatment sessions over the next five rounds of golf. Golfing rounds took place twice per week. A 60-day follow-up round of golf was conducted after treatment had ended. A.J. was asked not to change his putter or grip during the study. He was also asked to only image during the SFGI sessions and to continue his regular practice routines with no additional changes.

Five sessions using solution-focused guided imagery was conducted with each session lasting approximately 20-30 minutes. The researcher read aloud the 15 questions of SFGI and wrote down the participant’s responses of images. Following each session, A.J. was given a copy of the SFGI worksheet. Each session began by reading aloud the directions of SFGI, specifically reminding the participant to focus on things or actions that would be occurring as opposed to those that would not be occurring if the problem were solved. To better illustrate SFGI and ensure treatment integrity (Hryciako & Martin, 1996), samples of the questions used in the study are presented in the results section along with the client’s responses.

Results

Number of Yips Per Round

Visual inspection of Figure 1 reveals near immediate reduction of the frequency of occurrences of the yips. Figure 1 also shows an overall decrease in the number of yips (9.2) during baseline compared to treatment phase (.2). No overlapping data points were revealed across baseline and treatment phases. Visual inspection of Figure 1 shows two instances of the yips during the sixty-day maintenance phase.
Putting Accuracy

Visual inspection of Figure 2 shows that A.J.’s putting performance on putts equal to or less than four feet improved following the introduction of the treatment. Figure 2 reveals that during his baseline period, A.J. averaged 77% on putts made within four feet and increased to 97% of putts made within four feet. Visual inspection of Figure 2 also shows that no data points during the treatment phase were lower than the baseline phase. Visual inspection of Figure 2 reveals that A.J. made 81% of his putts of four feet or less during the sixty-day maintenance phase.

![Figure 2. Percentage of Made Putts within Four Feet](image)

Interobserver Agreement

A.J.’s recorded instances of the yips were observed and separately scored by a playing partner. (IOA) revealed that 100% of yip occurrences as well as putting percentage were recorded by both parties.

Solution-Focused Guided Imagery

To help ensure treatment integrity (see Hryciako & Martin, 1996 for more discussion) the following responses represent the different numbered sessions to demonstrate the progression of answers. In addition, McKeel (1996) suggests that research has often overlooked clients’ perceptions of treatment. Therefore, the participants’ responses provide an opportunity to evaluate answers regarding insight and progression during SFGI sessions.

The first and last question of SFGI asks the client to rate the severity of the problem on a scale of (0) worst to (10) non-existent. A.J.’s self-ratings on the 0 to 10 scale improved every time at the conclusion of the session. A.J. self-reported scores of 1 and 2 for the first two sessions
respectively and initially rated his level for the next three sessions as a 7. At the conclusion to the first session, his rating improved to a 4. The second session revealed an increase to a 6. The following three sessions revealed an increase to an 8.

The second question of SFGI asks the client to picture and describe detailed behavior that he was doing during those times when the problem did not exist.

Consultant: “Picture what it would look like as if it were a video of the behaviors you would observe yourself start to do. Do not describe something you would not be doing.”
A.J: (1) “I would mark the ball, look at the line, and read the putt. I would take my practice swings, and then I would step up and address the ball. I would just roll the ball and exude confidence.”
A.J: (2) “I would be relaxed and stand behind the putt. I would read it and take two practice swings. I would address the ball and look and go.”
A.J: (3) “I would be relaxed and see it up to the green. I would be joking around with my buddies. I would read the putt and try to enjoy the moment.”
A.J: (4) “I would have confidence. I would read the putt and take my practice swings. I would look and let it go. I notice my weight is on my front foot, sort of my weight moving forward.”
A.J: (5) “I would be relaxed and talking with my buddies. I would read the putt, take my practice swings and set up. I would have my weight moving forward and on my front foot.”

The third question on SFGI is the “miracle question”. This question is designed to identify solutions to the problem not usually apparent.

Consultant: “With your eyes closed, imagine that a miracle happened tonight while you were sleeping, and this miracle solved your problem . . . when you awoke you realized you no longer had this problem. Picture in your mind what would be the first small sign that would show you were doing something differently.”
A.J: (1) “I realized about three holes in that I was not stressing over putts, I was confident. I would hit it at the hole and not think about yipping it.”
A.J: (2) “I picture missing a putt and it does not bother me. I feel like I have total confidence in my putting.”
A.J: (3) “I would feel totally relaxed and confident to make it; I would go through my routine and putt it.”
A.J: (4) “I feel relaxed and confident while I am on the green.”
A.J: (5) “Again, when I address the ball to putt, I feel totally confident and relaxed.”

Questions 4-7 emphasize having the client notice people in his life who would observe his new behavior. The client imagines these individuals’ reactions and his responses to these people. A.J. described his playing partners and wife as individuals who would notice these differences.

Question 4
Consultant: “Picture in your mind who would notice this different thing you would be doing and imagine how you think they would respond when they notice this different behavior. Do not describe something they would not be doing”
A.J: (1) “It would be a huge relief for them. I would stay relaxed and relieved. I would maybe
have a dip, they would say ‘Nice putt’ and move on.”
A.J: (2) “They would say ‘Nice putt’, but they would also sort of realize that they were in trouble. I would get that feeling by the way they reacted.”
A.J: (3) “My buddies would be more relaxed and gregarious. They would just tell me that I was ‘Rolling it great’ and ‘nice putt’.”
A.J: (4) “My partners would be relieved. They would say ‘Nice putt’ and move on. There wouldn’t be a lot of focus on it.”
A.J: (5) “My buddies would say ‘Nice putt’. We would joke around and move on.”

Question 5
Consultant: “Imagine what you would do in reply to the person’s response to your new behavior describe in the previous step. Do not describe what you would not be doing.”
A.J: (1) “I would be more relieved. I would say ‘thanks’ and move on. Just try and stay in the moment. I also would probably joke around with them too.”
A.J: (2) “I would actually probably say some smart ass remark like ‘I’m back baby’.”
A.J: (3) “I also would be more gregarious. Joking around, I think I would talk about anything other than golf.”
A.J: (4) “I would just be having fun and joking around. I would really be in the moment”
A.J: (5) “I would be joking around, enjoying the day and the moment of things.”

Question 6
Consultant: “Picture in your mind who else would notice this different thing you were doing and imagine how you think they would respond when they notice this different behavior.”
A.J: (1) “My wife. I would come home with no tension and she would be relieved. I think she would say ‘Thank God’ quietly. I know it would be a relief to her.”
A.J: (2) “My wife. She would ask ‘How did you play?’ She would know and she would be so positive and say ‘that is great’.”
A.J: (3) “Again my wife. She would be thankful. She would ask ‘How did you play’ and she would be glad.”
A.J: (4) “She would be relieved. She would ask how I did and be thankful about the whole thing.”
A.J: (5) “My wife would say something nice. She would be positive about the situation.”

Question 7
Consultant: “Imagine what you would do in reply to the person’s response to your new behavior described in the previous step. Do not describe something you would not be doing.”
A.J: (1) “I would be thankful. I would say ‘Oh yeah, I played well’ and say ‘it was such a relief’.”
A.J: (2) “I would respond positively. I would say ‘Thanks’ and then change the subject to her.
A.J: (3) “I would feel good that she felt good about it. I would say ‘Yeah it was awesome’ or something. I would change the subject then and probably not talk about it.
A.J: (4) “I know I would say ‘Thanks’ and then just move on with the conversation.
A.J: (5) “I would thank her and say ‘Yes it was great.’ I would talk about whatever she wanted to talk about.”

Question 8 of SFGI re-emphasizes the miracle question by asking the client to identify exceptions to the problem or times when the problem is not happening.

Consultant: “Picture in your mind a time when you’ve been having this problem yet some of this miracle has already happened, even if only a little bit.”
A.J: (1) “I would step over the ball and go over my routine. I wouldn’t feel tension; I would feel
confident and relaxed.”
A.J: (2) “I stood up over the ball and I am getting ready to putt. I feel real loose, especially in my hands and my shoulders.”
A.J: (3) “I go through my same routine and I stand beside the ball and take a couple of practice swings. I look at the hole and ball and I move my weight on my front foot. I just roll the ball and give it a chance.”
A.J: (4) “I mark my ball, and I go through my routine. I feel relaxed and I think; ‘Let it go’.” I have my weight forward and I am just focused on the speed of the putt.”
A.J: (5) “I go through my same routine. I move my weight forward and I am relaxed. I just roll the ball and give it a chance.”

Question 9 elaborates on the previous step by having the client focus on how he made this miracle happen.

Consultant: “Picture in your mind how you made this part of your miracle happen during this problem time. It could have been things you thought of or tried that were different.”
A.J: (1) “I think about anything but putting. I am forcing my mind to joke with my friends and talk. I look at the trees and enjoy the moment.”
A.J: (2) “My mind was not on putting. I was joking with my buddies, watching the sky. I was taking in the whole environment.”
A.J: (3) “I was focused on just playing golf. I was having confidence that I was going to make it. My mind was on my friends until it was my turn.”
A.J: (4) “My mind is clear, I am in the moment. I am thinking about being relaxed.”
A.J: (5) “I thought about anything but putting until it was time. I just thought about giving it a chance, with confidence though.”

Question 10 through 13 addresses having the client rate the problem at its current state (0 to 10). The client is asked to picture why he is at the selected number and to imagine a number 10% higher on the scale and the different behavior required to reach that number.

Step 14 is intended for the client to write himself a short note as a reminder about the situation. This note is similar to a consultant-prepared note, yet different in that the athlete is thought to have ownership of the message (DeShazer et al., 1986).

Consultant: “Write yourself a short note describing what you discovered or re-discovered about your situation.”
A.J: (1) “Relax. Enjoy the game. Be confident. Enjoy your buddies. Have confidence that you’re going to make the putts.”
A.J: (2) “It’s just a game and you’re out there to have fun. Get out of your own way. Let golf take care of golf.”
A.J: (3) “You know you putt well. Remind yourself that you can make putts.”
A.J: (4) “Have confidence you can make putts. Relax and have fun.”
A.J: (5) “Have confidence. Remind yourself that you’re a good putter and can make putts.”

At the conclusion of the intervention phase, two structured interview questions were
addressed regarding the participant’s experience with SFGI. In response to the question, “How has the work with the solution-focused guided imagery helped with your putting?” A.J. stated,

It made me feel more confident and more at ease for some reason. It felt I had a feeling of what it was like to putt well and when I was on the green I was able to feed off of it. I had a feeling of being there before, a feeling of confidence.

When asked, “Why do you think the solution-focused guided imagery has helped with your putting?” He replied,

I am not sure and I am not totally convinced. It taught me that the yips are mental and not some physical ailment. It did get me more focused like I was on a mission when I stepped on the green. It also helped me make me know what it was like to feel like I had been there before. That feeling took up the space of feeling the yips.

**Discussion**

An exploratory attempt was made to determine the effectiveness of solution-focused guided imagery with a golfer suffering from the yips. Based on previous research (Sklare, et al., 2003) it was reasoned that systematic practice of SFGI would diminish instances of the yips.

Results suggest that SFGI reduced A.J.’s instances of yip related behavior. Visual analysis of the data revealed an immediate and overall decrease in yips occurrences from an average of 9.2 to .2 per round. In conjunction with previous literature and single-subject design research (Barlow & Hersen, 1984; DeShazer et al., 1986), these results revealed immediate improvements. Specifically, A.J. only displayed one occurrence of the yips throughout the intervention phase of the study.

An assumption of SFGI is that a focus on positive behavior and images of putting devoid of the problem diminishes the severity and frequency of the problem. This explanation coincides with research suggesting that facilitative imagery is beneficial for sport performance (Short et al., 2002; Woolfolk et al., 1985). Coinciding with SFBC literature, focusing on the solution of the problem appeared to create imagery sessions that promoted beneficial cognitive appraisal and picturing optimistic outcomes (Gutkind, 2004; Sklare, 2005). Specifically, the steps of scaling, identifying exceptions, and addressing the miracle question contributed the most to effective change (DeShazer et al., 1986).

First, the scaling question revealed an increase in number after every SFGI session. According to Sklare et al., (2003) higher self-ratings regarding the scaling question provide an indication that participants are moving closer to a problem solution by the end of a guided imagery session. The exception and miracle questions (see questions 8 & 9) also appeared to provide A.J. with a specific plan of overcoming the problem. This is evident in the identification of beneficial images throughout the progression of sessions. A.J.’s recognition of strategies devoid of the problem led to the application of effective behavioral goals. These behavioral goals also became evident in the composition of a written message at the end of each session. These messages served to summarize the session and to establish a behavioral goal for putting, which
was evident in the repeated theme of “have confidence” throughout the sessions.

At the conclusion of data collection, A.J. admitted that his negative thoughts, tension, and occurrences of the yips had severely diminished, however some feelings of anxiety remained. He expressed apprehension that the yips could still resurface. This explanation is two-fold. First, his feelings of apprehension signify the magnitude of A.J.’s yips. The longevity of playing with the yips offered a significant challenge regarding the effectiveness of SFGI. Before the sessions commenced, the participant anecdotally revealed skepticism concerning any possible success with the intervention. Second, the participant’s apprehension regarding the yips also suggests a significant mental component. This possible mental component may take the form of doubt or a lack of self-efficacy regarding overcoming the yips. This explanation coincides with research suggesting that performance anxiety may exacerbate feelings or symptoms of the yips (McDaniel et al., 1989; Sachdev, 1992; Smith et al., 2003).

There are important limitations to this study that should be considered. The greatest limitation of this study is the case study design. In general, case-studies are unable to control for possible rival hypothesis (Barlow & Hersen, 1984) and are the major limitation and a reason for there limited number of case studies in the literature. Future single-subject design research with more participants may help clarify the effectiveness of the SFGI with golfers with the yips. For instance, a multiple baseline design with several participants is an effective applied research design and can control for possible threats to internal validity (Winn, Skinner, Allin, & Hawkins, 2004). Second, although SFGI and SFBC are ideally brief, future research with both methods should be longer term until achievable performance goals are realized, as evident in the reoccurrence of yip-related behavior during the no-treatment 60-day follow-up phase. Longitudinal research may provide favorable support for continued benefits of the intervention. Sustained SFGI practice may be necessary to effect long-term improvement.

Nonetheless, the contributions of the current case study offer an avenue to be further researched. Great potential was revealed for reducing instances of the yips and further studies should explore the effectiveness with the SFGI. While the participants’ occurrences with the yips did not fully dissipate, the effectiveness of the solution-focused brief counseling appeared promising. In summary, the study suggests that interventions using solution-focused guided imagery with a golfer having the yips may decrease the number of yips and the number of putts per round of golf.
References


