JOURNAL OF APPLIED SPORT PSYCHOLOGY, 21: 1–14, 2009

ISSN: 1041-3200 print / 1533-1571 online
DOI: 10.1080/10413200802443776

Decreasing Putting Yips in Accomplished Golfers via Solution-Focused Guided Imagery: A Single-Subject Research Design

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An across-subjects multiple-baseline design was used to evaluate the effects of solution-focused guided imagery (SFGI) on putting yips (e.g., jerk in the putting stroke) in three experienced (24 years or more), accomplished (handicap less than 7), male golfers located in the Southeastern United States. Each golfer participated in at least five SFGI sessions designed to guide him to create vivid images of thinking, feeling, and behaving in ways devoid of the problem (i.e., putting with a smooth continuous stroke). Data collected during participants' regularly scheduled weekly golf rounds showed an immediate and sustained decrease in yips after SFGI sessions. Maintenance data collected three weeks after the last sessions showed that these decreases were maintained. Discussion focuses on future research and practice related to treatment of the yips and similar focal hand dystonia.

Putting yips are an interruption in the putting stroke with symptoms often described as jerks, tremors, or freezing of the stroke (Smith et al., 2000). An estimated 30% of experienced golfers have had the yips (Smith et al., 2000) and although the yips can emerge in any golf stroke (Achenbach, 2004; Haney, 2004), they are typically present during short putts (Smith et al., 2003). Those afflicted with the yips are often accomplished golfers with considerable playing experience (McDaniel, Cummings, & Shain, 1989; Sachdev, 1992; Smith et al., 2000). For example, Harry Vardon, Bobby Jones, Bernhard Langer, and Sam Torrance have each experienced this affliction at some point in their career (Achenbach, 2004; Palmer & Dobereiner, 1986).

Putting yips have been characterized as a task-specific dystonia (Smith et al., 2003). Similar focal hand task-specific dystonia have been studied in accomplished and experienced musicians and other professionals (Byl, 2004; Grafman, Cohen, & Hallet, 1991). Dystonia is characterized by sustained involuntary muscle contractions resulting in twisting, spasms, or flexing of a body part (Brin & Comella, 2004) and can range from generalized (multiple body part contractions) to focal (single body part contractions) to task-specific (e.g., writer's cramp,

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yips). Task-specific dystonia is a type of focal dystonia that is more sporadic than the other forms of dystonia and is primarily associated with the execution of certain types of movements (e.g., putting). Both physiological and psychological factors may influence the yips and other task-specific dystonia (Smith et al., 2003).

Researchers have used a variety of physiological measures to study the yips (Cook, 1993; McDaniel et al., 1989; Smith et al., 2003; Smith et al., 2000). Cook (1993) analyzed electromyogram (EMG) activity in 34 golf students, 17 with yips, and 17 without. Results revealed that increased overall forearm EMG activity occurred more frequently in yip-affected golfers than in non yip-affected golfers. In another study, Smith et al. (2000) examined heart rate (HR), grip force (GF), and EMG activity of four yip-affected and three non yip-affected golfers during several putting scenarios. Those with the yips had higher HR and greater GF and EMG activity during putting execution than non yip-affected golfers. These and other studies have led researchers to suggest that the yips may be associated with some sort of neurological and/or muscular dysfunction that occurs with repeated motor movement (Smith et al., 2003; Stinear et al., 2006).

Other researchers studying focal dystonia found evidence that psychological factors may cause or exacerbate symptoms (Byl, 2004; Cook, 1993; McDaniel et al., 1989; Sachdev, 1992; Smith et al., 2000; Smith et al., 2003). For example, Kolle (2000) found that musicians who experienced hand dystonia and/or fine motor control problems also reported higher levels of stress, anxiety, and persistent attention to improving their work. Smith et al. (2000) obtained 1,031 questionnaire responses from professional golfers and found that yip-affected golfers experienced increased anxiety when leading a tournament, attempting a difficult putt, facing specific competitors, and feeling the need to make the putt. These data are supported by other literature indicating that psychological factors such as stress and anxiety may exacerbate the yips and similar dystonia (Byl, 2004; Grafman et al., 1991).

As pressure increases, putters who experience anxiety may become distracted from the task at hand or turn their focus inward (i.e., self-consciousness), diminishing performance execution and lowering performance scores (Linder, Lutz, & Crews, 1999). Beilock, Carr, MacMahon, and Starkes (2002) found that skilled golfers performed worse while attending to the process of their putting stroke compared to those who attended to an external stimulus. Due to the preciseness of the task of putting, an internal focus during specific anxiety-producing situations may exacerbate the yips.

Although factors influencing the etiology and maintenance of yips are unclear, researchers using case study procedures have developed and evaluated treatments for the yips and other focal dystonia (Bell & Thompson, 2007; Byl & McKenzie, 2000). Solution-focused brief counseling (SFBC) and solution-focused guided imagery (SFGI), interventions derived from education and sport psychology (Gutkind, 2004; Hoigaard & Johansen, 2004; Sklare, 2005), may prove effective in reducing yips (Bell & Thompson, 2007). During SFGI, the facilitator guides the client in creating vivid images of thinking, feeling, and behaving in ways devoid of the problem (Sklare, Sabella, & Petrosko, 2003).

Perhaps the most often used performance enhancement technique in sport psychology is mental imagery. Numerous studies have revealed that imagery has been used effectively by performers in various sports (see Martin, Moritz, & Hall, 1999, for a review). 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). Others have found evidence that forming desired mental images directly affects neurological functioning (Decety, 2002; Dechent Merboldt, & Frahm, 2004; Stinear et al., 2006).

However, SFGI includes more than forming appropriate mental images. SFGI is based on the assumptions and procedures of SFBC which provide theoretical guidance and support for applying solution-focused techniques (Walter & Peller, 1992). These include, first, focusing on solutions rather than on problems. Solution-focusing can result in beneficial changes via addressing what is working in a client's life versus what is not and can also spill over into other areas of the client's life. Second, every problem has exceptions that can be identified and turned into solutions. In SFBC, uncovering exceptions (i.e., instances when the problem has not occurred) provide a means of assessing progress even in the first session. For example, Weiner-Davis, de Shazer, and Gingerich (1987) found that clients reported positive change almost immediately, caused by a de-emphasis on problems and noticing exceptions. Third, small changes can have a ripple effect that expands into greater change. This means that all problems are first solved a little bit at a time; approaching change in this manner also breaks down larger goals into more reachable goals (Weiner-Davis et al., 1987). Manageable goals may provide the client confidence and serve as a catalyst for change. Fourth, the client is assumed to be the expert in his/her own life and has the needed skills to resolve one's problems. This places responsibility on the client him/herself to determine on what s/he wants to work. Fifth, goals are viewed in positive terms and should mirror what the client wants to do as opposed to something the client wants to stop doing (see Weinberg & Gould, 2006 for a review of goal-setting).

Bell and Thompson (2007) investigated the effects of SFGI on an accomplished male golfer (handicap under 5) who had been experiencing putting yips for approximately 3 years. After five SFGI sessions, the golfer's yips were reduced from 9.2 per round to 0.2 per round. The authors reasoned that SFGI helped the golfer create successful imagery scenarios that focused on the solution to the problem in a relatively short time period. Although Bell and Thompson's results were promising, their case-study approach provided little evidence of external or internal validity (Campbell & Skinner, 2004).

Thus, the purpose of the present study was to extend the research of SFGI and putting yips in several ways. First, an across-subjects multiple-baseline design was used to control for threats to internal validity and allow for rapid and repeated evaluations of treatment effects (Kazdin, 1998; Ray, 2003; Skinner, 2004). Second, interobserver agreement data were collected to rule out changes in yips caused by observers collecting data inconsistently (i.e., instrumentation). Finally, an attempt was made to enhance the external validity of the current study by collecting data on three golfers.

METHOD

Participants

Upon institutional review board approval, participants were recruited from local golf courses within 50 miles of the local university in the Southeastern United States. Three male Caucasian right-handed golfers ($M = 51$ years of age) completed this study. A fourth golfer began the study and completed four rounds of baseline, but was unable to complete the required rounds of golf because of scheduling conflicts. Inclusion criteria for each golfer were consistent with past yip-related research (Smith et al., 2003). All participants were experienced (>24 years), accomplished (highest handicap was 6), and regular (typically at least twice a week) golfers. Finally, all participants reported experiencing observable yips, operationally defined as a "twitch, jerk, freezing, or flinch of the putting stroke" (Smith et al., 2003, p. 14). Storm, Commish, and Struts were the three pseudonyms chosen by each golfer, respectively.

Setting

The study took place at each participant's regular 18-hole golf course in a metropolitan area in the Southeastern United States. Each golfer agreed to continue his usual playing routine of at least nine holes of golf twice a week with the same group of players/fellow golfers, often with some sort of small wager as per his typical routine. Typical routines, as opposed to practice greens, were used because previous research suggest that stress may acerbate yips (e.g., Byl, 2004; Grafman et al., 1991; Smith et al., 2000) and interviews with the participants suggested that they rarely experienced the yips on the practice green. Additionally, the participants and researchers wanted to reduce yips during their typical rounds of golf, *in vivo*.

Design and Procedure

In the current study, an across-subjects multiple-baseline design was used to evaluate the effects of the SFGI intervention (Bolton, Lalli, Belfiore, & Skinner, 1994). Trained observers collected each participant's data across three phases: baseline, intervention, and maintenance. To control for threats to internal validity, intervention implementation was staggered across participants. When interventions have an immediate effect on target participants' behavior, this design allows for multiple replications of a possible treatment effect. Thus, if some other event caused the change (e.g., history effect), the improbability of this event occurring at the exact time the intervention was applied across three separate participants should control for history effects (Hayes, 1985). Additionally, when those still in baseline show no change in target behavior as the intervention is applied to others, other threats to internal validity (e.g., testing and maturation) are unlikely to account for the changes in behavior (Kazdin, 1998).

Researchers evaluating interventions designed to change behavior in natural settings often use direct observation and systematic data collection procedures. Because the assumption is that the behavior will change, constructs that assume stability such as test-retest reliability cannot be used to evaluate the quality of the data. Rather, researchers have a second independent observer and record data to provide evidence that instrumentation (e.g., the process of collecting data caused the observer to collect data differently over time) did not account for the results.

During the *baseline phase,* the trained observer(s) used a golf cart to travel around the course. When the participant was putting, the observer(s) stood off the green and observed and recorded data on the putting strokes (this is explained in greater detail below). During the *intervention phase,* the first participant began the intervention after four baseline rounds of golf. The second and third participants completed the baseline phase and started the intervention after five rounds of golf. However, one of these participants dropped out of the study because of scheduling conflicts. The fourth participant completed seven baseline rounds of golf before beginning the intervention phase. Maintenance data were collected during a golf round that was completed 3 weeks after the final SFGI treatment session.

Once a participant began the intervention phase he arrived at the course early and took part in a 20-min SFGI session with the primary researcher (see Appendix). The researcher wrote out participants' responses to each question used in the SFGI session as part of data collection. Storm and Struts completed the five planned SFGI sessions. An additional session was added for Commish because his treatment phase data showed a slight increase in yips following the fifth session. During the *maintenance phase,* data were collected 3 weeks after the final SFGI session. During maintenance sessions, the trained observer(s) merely collected data. Thus, these sessions were similar to baseline sessions.

Data Collection Procedures and Dependent Variables

During each 9-hole round of golf, one or two trained independent observers used a golf cart to move around the course and record putting data for the participants. Observers recorded putts on the green, putts on the green from 1.524 meters (5 feet) or less, and the presence of a yip. A yip was operationally defined as a flinch in the dominant hand during a putting stroke (e.g., Smith et al., 2003). The dependent variables for this study were total number of yips per nine holes and percentage of short putts 1.524 meters (5 feet) or closer with a yip.

Data Analysis

For each dependent variable, data were graphed and visually analyzed to evaluate the effects of the intervention (Barlow & Hersen, 1984). These graphs were interpreted with respect to immediacy and level of change across phases, amount of overlapping data points across phases, and changes in slope and/or variability across phases (Hrycaiko & Martin, 1996; Thelwell, Greenlees, & Weston, 2006). Effect size for each category was also computed to help gain an understanding of the data. Effect size was conducted using mean baseline reduction (MBLR; Campbell, 2004). Effect size measures the index of how much impact a treatment has on the dependent variables and can range from small (.20), moderate (.50), to large (.80; Murphy & Myors, 1998).

Interobserver Agreement and Treatment Integrity

Throughout the study, three trained independent observers (two undergraduate psychology students and a graduate student in sport psychology) collected direct observation data. Training consisted of demonstrating the data collection procedures and collecting independent data across all four participants.

During the baseline, intervention, and maintenance phases, inter-observer agreement data were collected across 48% of the total rounds, exceeding the generally accepted level of 20% (Kazdin, 1998). During these rounds, two of the three observers recorded putting data for each participant in at least one round during the baseline and intervention phases. Inter-observer agreement was 100% on number of putts and number putts $\leq$5 feet. There was only one disagreement over the presence of a yip. This nearly unanimous agreement suggests that observers did not alter their recording procedures (observer drift), due to factors such as expectancy effects.

Requiring the golfers to verbalize their responses to each SFGI question allowed the first author to evaluate treatment integrity and provide some indirect evidence that they were imaging appropriately. Recordings of golfers' responses indicated a few instances when an additional prompt (e.g., "Describe what you would be doing . . . ") was needed to elicit this information. Lastly, at the conclusion of all data collection, participants were given a treatment acceptability form (Witt & Elliott, 1985). This measure was utilized to help assess the participants' overall experience. Participants found the SFGI intervention to be "useful", "easy to apply", and felt it helped with their problem.

RESULTS

Yips Per Round

Figure 1 displays the data on number of yips per 9-hole round for each participant across all phases. Visual analyses of Storm's yips-per-round show variable baseline phase data with no

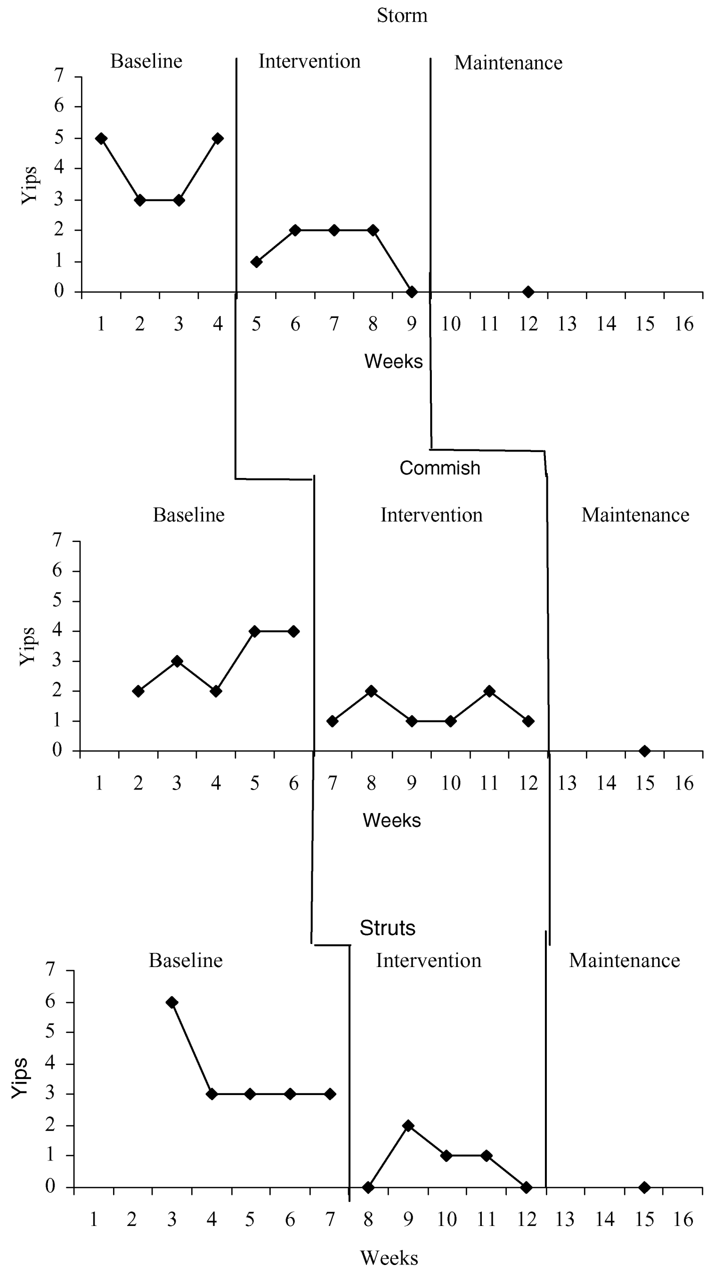

Figure 1. Number of total yips.

clear trend. However, immediately after the intervention was applied, Storm showed a decrease in yips per round. Throughout the intervention phase Storm's yips per round remained lower than his best performance in baseline (i.e., no overlapping data points). During the four baseline rounds Storm's yips per round averaged 4 (range = 3–5). Throughout the intervention phase of the study (five rounds), Storm's yips per round decreased to 1.4 (range = 0–2) Effect size data comparing Storm's baseline and intervention phase was moderate at .65 for number of yips per round. No yips were observed during Storm's maintenance round.

Figure 1 shows that Commish's yips per round were increasing during baseline. Immediately following the application of the first SFGI session this increasing trend was reversed and Commish maintained his yips per round between 1 and 2 throughout the intervention phase. Across phase comparisons reveal that Commish's yips per round never exceeded 2, his best performance during baseline. Commish's baseline phase yips per round averaged 3 (range = 2–4). During the intervention phase Commish's average yips per round decreased to 1.3 (range = 1–2). Effect size between baseline and intervention phases for yips per round was moderate at .55. No yips were observed during Commish's maintenance round.

For Struts, Figure 1 shows that during baseline he exhibited his highest level of yips per round during the first session (6 yips) followed by four stable sessions of 3 yips per round. Immediately following the application of the intervention, Struts' yips per round were reduced to 0. Although Struts showed variable performance during the intervention phase, throughout the phase his yips per round were lower than 4 (i.e., no overlapping data points). During the five baseline phase rounds, Struts' yips per round averaged 3.6 (range = 3–6). During the intervention phase, Struts' average yips decreased to 0.8 (range = 0–2). Effect size comparing Struts' baseline and intervention phases indicated a moderate effect size of .73 for yips per round. No yips were observed during Struts' maintenance round.

Across all participants, Figure 1 shows immediate and sustained decreases in yips per round after the intervention was applied. Furthermore, none of the three golfers showed a decrease in yips per round during baseline that coincided with the application of the treatment to a fellow participant. Effect size calculations showed a moderate decrease in the number of yips across participants. Additionally, maintenance data showed that no participants yipped during their maintenance round occurring 3 weeks after their final intervention session.

Percentage of Short Putts with a Yip

Researchers have found evidence suggesting that yips are more likely to occur on short putts than longer ones (e.g., Smith et al., 2000). By converting frequency data to percentages and only including short putts, we hoped to obtain data less susceptible to variability caused by number of short putts attempted per round. Figure 2 displays the data for the percentage of short putts with a yip per round on putts from 5 feet or less.

Across all participants, Figure 2 shows no decreasing baseline trends in the percent of short putts with a yip per round. Each participant showed an immediate decrease in percentage of short putts with a yip following the initial intervention sessions. Additionally, with the exception of two overlapping datum points (one for Storm and one for Commish), performance during intervention rounds remained stronger than participants' best performance during the baseline. Both Storm and Struts reduced their percentage of short putts with a yip on the final intervention sessions. Because Commish showed a small increase in percentage of short putts with a yip following his fifth SFGI session, an additional session was run. This increase proved less of a concern in that Commish's maintenance round data showed no yips.

During baseline, Storm's percentage of short putts with a yip averaged 35.5% (range = 25%–50%). During the intervention phase, Storm's average decreased to 15.5% (range = 0%–25%). Effect size comparison between baseline and intervention phases for Storm's percentage of short putts with a yip was moderate at .57. For Commish, percentage of short putts with a yip decreased from an average of 30.6% during baseline (range = 18%–37%) to an average of 12.9% (range 0%–18%) during the intervention phase. Effect size comparison

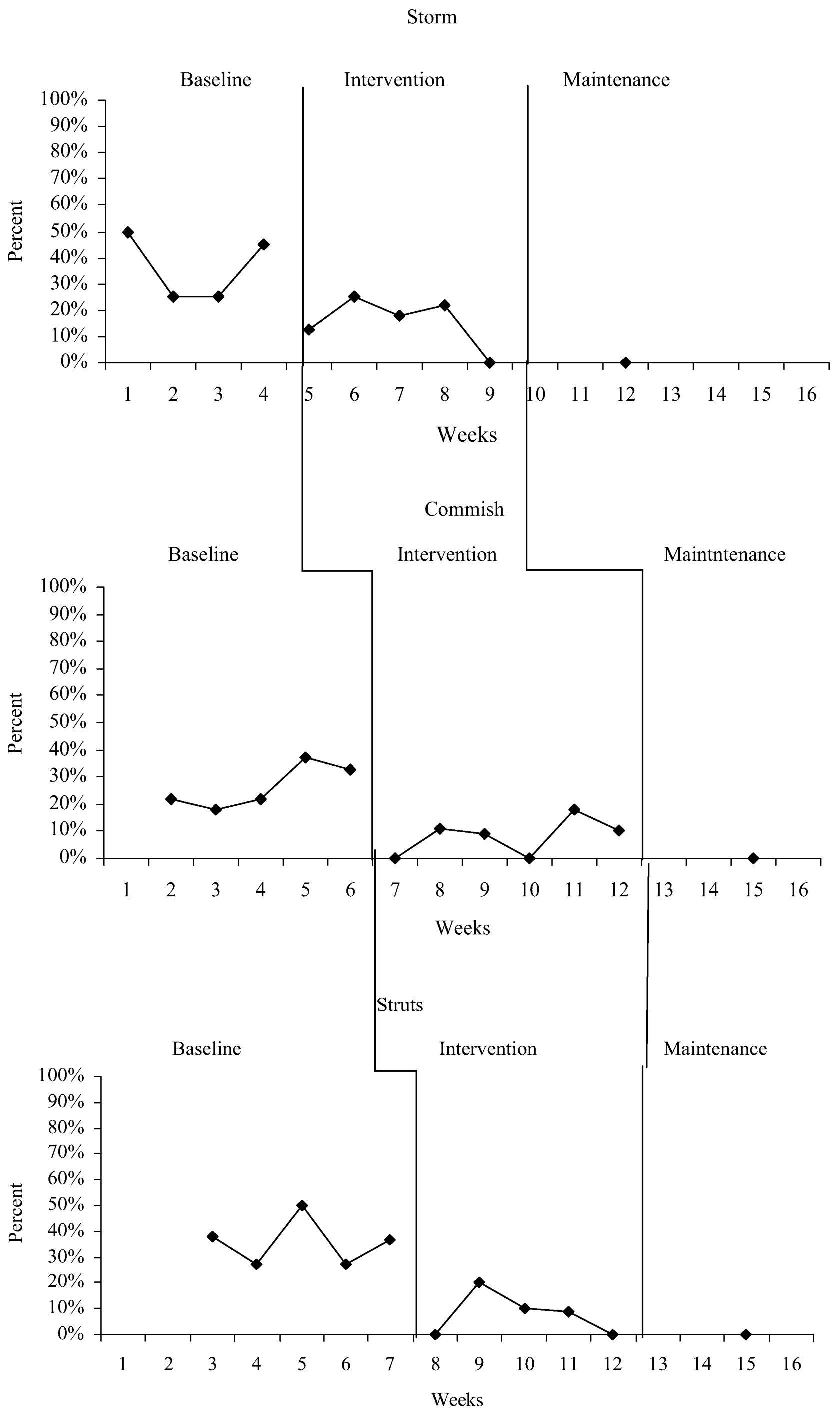

Figure 2. Percentage of short putts with a yip.

between baseline and intervention phases for percentage of short putts with a yip was moderate at .57. For Stuts, the decrease was even larger from an average of 36.7% (range = 27%–50%) during baseline to an average of 8% (range = 0%–20%) during the intervention phase. Effect size comparison of percentage of short putts with a yip between baseline and intervention phases was moderate at .77. None of the participants yipped on putts within 5 feet on their maintenance round completed 3 weeks after the final SFGI session.

DISCUSSION

Bell and Thompson's (2007) case study suggested that SFGI could reduce yips, but the design did not control for threats to internal validity. The current study extends this research by using a multiple-baseline design to evaluate the effects of SFGI on putting yips. Results showed all participants experienced an immediate and sustained decrease in yips per 9-hole round and in the percentage of short putts with a yip. Based on the logic of the improbability of successive coincidences (Hayes, 1985), it is unlikely that some event outside the treatment procedures (e.g., history effects) caused the reduction in yips.

Across-subject, across-phase comparisons showed that after the intervention was applied to one golfer, the golfers still in baseline did not experience a simultaneous (concurrent) decrease in yips. These results suggest that the process of being assessed (e.g., participant anxiety being reduced as they become habituated to having data collected) and maturation did not cause the reduction in yips (Barlow & Hersen, 1984; Kazdin, 1998; Ray, 2003). Furthermore, interobserver agreement data suggest that inconsistent measurement (e.g., observers who were not blind changing their data collection procedures across phase due to expectancy/Rosenthal effects) did not account for the recorded decrease in yips (Skinner, 2004).

By using a multiple-baseline design and providing three replications of treatment effects, the current study provides additional evidence that SFGI can be used to reduce putting yips. Data collected 3 weeks after the final SFGI session suggest that this decrease was maintained. Also, the current study enhances the external validity of the Bell and Thompson (2007) case study by replicating intervention effects across participants and settings (i.e., three different golfers on three different courses).

The current study has applied value in that it suggests that SFGI has the potential to decrease the yips in experienced and accomplished golfers during their typical rounds of golf. Various psycho-physiological models suggest that fear of an event can lead to increased physiological and psychological burden, which can emerge with thoughts of doubt or worry and increased muscle tension (e.g., Bandura, 1989; Heil, 2000; Krane & Williams, 1992). Because past instances of the yips would serve to only further exacerbate anxiety, doubt, fear, and/or worry, this perceived threat could lead to a negative cycle of doubt and muscle tension which could perpetuate the yips (Chase, Magyar, & Drake, 2005; Smith et al., 2003). Of note within this study is the dramatic reduction in participants' yips behavior. Although the real-world setting added to the internal and external validity, further research aimed at yip interventions is warranted.

Thus, researchers should conduct studies to determine if SFGI sessions decreased yips by moderating physiological arousal through having them think, feel, and behave in ways devoid of the problem. To better assess these causal models, researchers should consider conducting similar studies and collecting psychological (e.g., self-efficacy, anxiety, stress, and/or fear) and physiological (e.g., heart rate, grip force) data prior to and following treatment. Also, researchers could experimentally manipulate anxiety and stress by altering contextual variables (e.g., downhill versus uphill putts, audience presences or absence, consequence versus no consequences for results) that affect stress (see Smith et al., 2000; Stinear et al., 2006).

During the fifth round of the intervention phase, Commish showed a slight increase in yips. Therefore, another SFGI session was run. Future researchers should conduct additional studies with standard protocols as Commish's maintenance data suggest that this slight increase in yips may have just been typical variance as opposed to a trend. Also, future researchers should take more maintenance data over longer time intervals. If yips return, researchers should consider determining if a single brief SFGI session (i.e., a "booster" session) can alleviate the re-occurrence of yips.

In the current study each participant volunteered. Therefore, each may have been highly motivated to improve. Additionally, the same facilitator administered SFGI to all three golfers. Thus, the golfers may have been influenced by their motivation, their relationship with the facilitator, or some other subtle influence of this facilitator (e.g., expectancy or Rosenthal effects may have directly reduced yips). Similar studies conducted across golfers and SFGI facilitators are needed to enhance both the internal and external validity of the current study.

There may be different types of yip-affected golfers: Type I golfers whose task-specific dystonia may be neurological, Type II golfers whose dystonia is caused by psychological variables (e.g., anxiety and stress), and golfers whose dystonia is difficult to classify (Smith et al., 2000; Smith et al., 2003; Stinear et al., 2006). The current study did not attempt to classify golfers; thus, future researchers should attempt to determine if there is an interaction between yip type and SFGI and other psychological treatments. The methods used contained a typical sequence of SFGI techniques: scaling (self-monitoring and evaluation), identifying exceptions (problem-solving), addressing the miracle question (linking behavior change to consequences), and mental imagery. Research suggests that the mental imagery component of SFGI may directly alter neurological functions (Decety, 2002; Dechent et al., 2004; Stinear et al., 2006). However, the other components of SFGI (e.g., focusing on the solution and small steps) appear to be more focused on psychological factors such as reducing stress (Cook, 1993; Grafman et al., 1991; Kolle, 2000; McDaniel et al., 1989; Sachdev, 1992). Thus, future researchers may want to conduct studies investigating yip types by treatment interactions. Because each of these techniques has been shown to influence behavior change (see Kazdin, 2001; Stinear et al., 2006), component analysis studies are needed to specify the component(s) or interaction of components that are causally related to the reduction in yips. Also, researchers should determine if SFGI or similar procedures could reduce focal hand dystonia across other tasks (e.g., playing music, a tennis serve).

Summary

Although common and debilitating, the etiology and maintenance of the yips is unclear with both neurological and psychological factors possibly influencing the yips. However, from an applied perspective it is often possible to treat a sport psychology problem, even when the exact cause is unknown, and these treatments should be effective and simple (Giges & Petipas, 2000). Results of the current study suggest that SFGI may meet these criteria. However, the process of empirically validating interventions requires multiple studies conducted across researchers, participants, settings, and treatment agents (Chambless & Hollon, 1998; Drake, Latimer, Leff, McHugo, & Burns, 2004; Kazdin, 2004). Therefore, it is important that sport psychology consultants and other professionals are aware of and continue the research on the benefits of SFGI and other interventions that may alleviate these and similar psycho-physiological symptoms.

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APPENDIX

Solution-Focused Guided Imagery

Step 1

Close your eyes and picture a recent recurring problem that you would like to overcome. This could be something that you would like to do, or something you want to stop doing. Rate the severity of this problem from 0 (*worst it has ever been*) to 10 (*non-existent*) and write the rating in the space provided.

Step 2

Close your eyes. If your problem is something you want to stop doing, picture what you would be starting to do instead. 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. After you have visualized a mental picture, describe what you have pictured.

Step 3

With your eyes closed, imagine that a miracle happened tonight while you were sleeping, and this miracle solved your problem. Because you were sleeping you didn't know this miracle had occurred. When you woke up 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 different. After you have a mental image of this different behavioral action, describe what you would be doing. Do not describe something you would not be doing.

Step 4

With your eyes closed, 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. After you have a mental picture of this, describe what you have pictured. Do not describe something you would not be doing.

Step 5

With your eyes closed, imagine what you would do in reply to the person's response to your new behavior described in the previous step. Describe what you have pictured of how you would respond to that person. Do not describe something you would not be doing.

Step 6

With your eyes closed, picture in your mind who else would notice this different thing you would be doing and imagine how you think they would respond when they notice this different behavior and describe what you have imagined. Do not describe something you would not be doing.

Step 7

With your eyes closed, imagine what you would do in reply to the person's response to your new behavior described in the previous step. Describe what you have pictured, do not describe something you would not be doing.

Step 8

With your eyes closed, picture in your mind a time when you've been having this problem yet some of this miracle has happened, even if only a little bit. Describe what you have pictured. Do not describe what you would not be dong.

Step 9

With your eyes closed, picture in your mind how you made part of this miracle happen during the problem time. It could have been things you thought or tried that were different. Describe what you were doing to make some of this miracle happen. Do not describe something you would not be doing.

Step 10

With your eyes closed, imagine or remember your thoughts about how pleased you were with your efforts at the time. Describe your thoughts about what you imagined or remembered. Do not describe something you would not be doing.

Step 11

With your eyes closed, picture in your mind how you would now rate the severity of this problem from 0 (*worst it's ever been*) to 10 (*non-existent*).

Step 12

Close your eyes and imagine how you have gotten yourself to that number. Construct a mental image of how you made this happen. Describe what you have pictured.

Step 13

With your eyes closed, picture in your mind when you are one number higher on the scale. What will you and others see you doing that's different from what you have already done? Describe what you have pictured. Do not describe something you would not be doing.

Step 14

Describe a short note that you would write about what you have discovered or re-discovered about yourself and your situation.

Step 15

Rate the severity of the problem now that you have gone through this exercise, from 0 (*worst it has ever been*) to 10 (*non-existent*).

Note: Adapted from Sklare, Sabella, and Petrosko (2003).