Preliminary Evidence for the Treatment of Type I ‘Yips’: The Efficacy of the Emotional Freedom Techniques

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This study explored whether a meridian-based intervention termed the Emotional Freedom Techniques (EFT) could reduce Type I ‘yips’ symptoms. EFT was applied to a single figure handicap golfer in an attempt to overcome the performance decrements the player had suffered. The participant underwent four 2-hr sessions of EFT. The EFT involved the stimulation of various acupuncture points on the body. The appropriate acupuncture points were tapped while the participant was tuned into the perceived psychological causes (significant life event) associated with his ‘yips’ experience. Dependent variables included: visual inspection of the ‘yips’, putting success rate and motion analysis data. Improvements in ‘yips’ symptoms occurred across all dependent measures. Social validation data also illustrated that these improvements transferred to the competitive situation on the golf course. It is possible that significant life events may be a causal factor in the ‘yips’ experience and that EFT may be an effective treatment for the ‘yips’ condition.

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Applied sport psychologists are confronted with a variety of psychological issues that impact the performance of competitive athletes. One psychological issue that sport psychologists have had major difficulty treating is the affliction colloquially known as the ‘yips’. The ‘yips’ are a performance problem, which tend to affect simple motor tasks that up to the onset of the problem, the individual demonstrated no concern about performing (Smith, Malo, Laskowski, Sabick, Cooney & Finnie, 2000). The ‘yips’ generally develop into a long-term movement disorder that influences an individual’s ability to carry out a desired motor skill (Rotheram, Bawden, Maynard, Thomas & Scaife, 2006). The problem manifests itself in the guise of physical symptoms that have been demonstrated to interrupt task execution in golf putting/chipping, cricket bowling and the darts throw (Rotheram et al., 2006; Rotheram, Thomas, Bawden & Maynard, 2007).

Typically, performers learn short-term or ‘trick’ strategies to help overcome the ‘yips’; however, these strategies only tend to offer limited respite from the affliction, which on many occasions will return to affect the athlete’s performance (Bawden & Maynard, 2001; Rotheram et al., 2007). These short-term interventions have tended to be centered on technical modifications associated with the motor performance of the affected skill. For example, the golfer Bernhard Langer changed the grip he used on his putter and developed a completely new technique on four separate occasions in an attempt to combat the ‘yips’ within his putting stroke (White, 1993). While technical modifications can provide some relief for golfers, it is difficult to use such technical or short-term strategies to change the nature of the bowling action in cricket or the darts throw. Given the severe nature of the problem, and the impact it has on performance, it is important to explore additional interventions that may impact positively the ‘yips’.

Research examining the ‘yips’ has suggested they are a psycho-neuromuscular condition that lie on a continuum by which focal dystonia (Type I) and choking (Type II) anchor the extremes (Smith, Adler, Crews, Wharen, Laskowski & Barnes, 2003; Stinear, Coxon, Fleming, Lim, Prapavessis & Byblow, 2006). Focal dystonia is characterized by involuntary movements such as spasms, twisting and posturing of a body-part specific to the execution of the task. Choking is the result of attentional disturbances caused by self-focus and/or “distraction” (Beilock & Gray, 2007).

Recent research has shown that Type II ‘yips’ can be alleviated through traditional psychological skills strategies. For example, Mesagno, Marchant and Morris (2008) used a single-subject design and follow-up interviews to ascertain the impact of a preperformance routine (PPR) on three experienced tenpin bowlers who were ‘chokers’. The results indicated that PPR prevented Type II ‘yips’ through the reduction of self-focus and distraction. In a second study, Mesagno, Marchant and Morris (2009) required inexperienced basketball players to perform a free throw while focusing on words to a song that had been played to them before the task. Both studies revealed that PPR had a positive impact on Type II ‘yips’.

However, the use of interventions to overcome Type I ‘yips’ seem to have been less successful and have seldom tended to do little more than provide brief relief from the symptoms. The short-term or ‘trick’ strategies seem to have been more widely used to treat Type I ‘yips’ and this approach has been documented in the sporting context (Bawden & Maynard, 2001; Rotheram et al., 2007). Likewise, in other performance domains such as professional music, research has revealed marked improvement from dystonic symptoms with the use of “sensory tricks”
including playing with latex gloves or holding objects between the fingers (Jabusch & Altenmüller, 2006). Importantly, the role of psychological interventions in treating problems at the dystonic end of the continuum has seldom been investigated. Therefore, it is important to understand how psychological factors influence the onset and development of the problem.

The occurrence of psychologically significant life events may play a role in the onset of varying forms of focal dystonia (cf., Baker & Humblestone, 2005; Lees, 2002; Schmidt, Wisser & Heitmann, 1994; Schweinfurth, Billante & Couray, 2002; Thomas, Vuong & Jankovic, 2006). These problems have been labeled as psychogenic movement disorders. The disturbances have been attributed to dissociation theories and conversion disorders (Baker & Humblestone, 2005). Psychological pain (e.g., the significant life event) is converted to physical symptoms to act as a defense mechanism, preventing individuals from accessing the memory of the painful event (Baker & Humblestone, 2005). Environmental triggers can then lead to the reexperiencing of the physical sensations but the memory of the event remains unrecalled (Brown, 2004). Rotheram et al. (2007) reported similar results in the sporting context when they found that ‘yips’ affected individuals often report the occurrence of major life events (e.g., death of parent, relationship breakdown) before the initial onset of the ‘yips’ problem. This finding may be important in that it identified a link between the onset of the ‘yips’ and a significant life event that sportspeople had experienced. According to dissociation theory, it could be that environmental triggers are present on the first occurrence of the ‘yips’, which caused the experience of the physical symptoms. Similarly, Bawden and Maynard (2001) found that significant sport-related events (e.g., arguments with teammates, a dropped catch, first game for a new team) occurred immediately before the onset of the first experience of the ‘yips’ in cricket bowlers.

If Type I ‘yips’ are a psychogenically-based problem in the form of trauma, masked by physical symptoms, then it would be wise to examine treatment protocols that could be readily applied by sport psychology practitioners. Numerous protocols are available for the treatment of trauma. A recent meta-analysis revealed that cognitive behavior therapy, exposure therapy, and eye-movement desensitization and reprocessing tended to be efficacious therapies in the treatment of trauma-based problems (Bradley, Greene, Russ, Dutra & Western, 2005). Of those interventions, there is currently greatest support in the literature for Cognitive Behavioral Therapy (CBT; Jaberghaderi, Greenwald, Rubin, Zand & Dolatabi, 2004). However, several limitations have been associated with such programs when treating trauma (Jaberghaderi et al., 2004). For example, CBT programs are often lengthy, and the client must give up a significant amount of time in order for the intervention to be learned and become habitual. Further, for trauma related problems, CBT has only been associated with intermittent short-term success (Jaberghaderi et al., 2004).

Emotional Freedom Techniques (EFT) is a relatively young therapy in research terms, but one which has been used in numerous case studies over the past 15 years for a range of trauma-based issues (e.g., Post Traumatic Stress Disorder [PTSD], specific phobias; see Flint, Lammers & Mitnick, 2006). EFT involves the stimulation of various acupuncture points on the body through tapping while the participant is tuned into the psychologically significant life event related to their trauma. Some proponents of EFT and other energy psychology (Callaghan, 1985; Craig, 1999) methods attribute the efficacy of the treatment to the location of the tapping
points, which are situated on the endpoints of acupuncture meridians as described in traditional Chinese medicine (Gallo, 1999). However, others ascribe the positive results of EFT to more conventional psychobiological mechanisms, such as decreased hyper-arousal of the limbic system and other brain structures involved in the fight-or-flight response generated by exposure to trauma (Feinstein, 2008) and changes in the amygdala and anterior cingulate areas of the brain (Felmingham, Kemp, Williams, Das, Hughes & Peduto, 2006).

Empirical research into EFT has only been conducted over the last decade and reports have tended to be positive. For example, Swingle, Pulos and Swingle (2001) conducted a pilot study on the effects of EFT on auto accident victims who were suffering from PTSD. They reported significant improvements in the patients’ brainwaves and self-reported symptoms of stress three months after they had received two 1-hr sessions of EFT treatment. Church and colleagues’ provided a similarly positive trend of results when using EFT to treat PTSD in groups of war veterans (Church, Geronilla & Dinter, 2009; Church, 2010). Specifically, after six sessions of EFT with Iraqi and Vietnam war veterans, significant decreases in PTSD, depression and anxiety, were found and the breadth and severity of psychologically debilitating symptoms remained more positive post treatment and follow-up (one year later).

Evidence has therefore emerged that has indicated significant life events to be a potential causal factor in the ‘yips’. The literature also seems to contain a paucity of research examining effective intervention protocols in this area of research. Therefore, the purpose of this study was to investigate if EFT could reduce the symptoms of Type I ‘yips’ experienced by a golfer. A secondary aim of the study was to assess whether treating significant life events that were associated with the onset of Type I ‘yips’ would impact positively on ‘yips’ symptoms.

**Method**

**Participant Selection Criteria**

An online database developed in previous research (Rotheram et al., 2006, 2007) was used to identify a self-reported ‘yips’ afflicted sports participant. To qualify as a potential participant for the study the person was required to have positively responded to at least one of the following criteria: an inability to perform a certain part of the sport that could previously be performed with ease; an extreme fear of performing; an extreme lack of control over the skill being performed; a long-term movement problem; and the experience of a jerk, tremor, twitch or trembling. Of those who were eligible for this study, additional criteria to take part in this intervention included participants who were: (a) over 18 years of age, (b) currently experiencing the physical symptoms of the ‘yips’ in their respective sport, (c) not currently receiving any treatment (physical or psychological) for their ‘yips’, and (d) the occurrence of a significant life event that had occurred before their first ‘yips’ experience.

A golfer was identified and underwent an initial prescreen interview to check his eligibility for inclusion. The 49-year-old male had a handicap of 4 before developing Type I ‘yips’, which he had been suffering from for a period of 6 years. The
golfer experienced an involuntary disturbance, in the radial area of the left arm when putting with a right-handed posture from any distance within 6 feet of the hole. The participant stated the ‘yips’ were always prevalent when putting from within this distance. The disturbance occurred on impact with the ball. In the prescreening interview the participant indicated that he experienced the ‘yips’ for the first time on the 18th green at his local club, during his first game after a winter break. Before the winter break, at a meeting, in the clubhouse overlooking the 18th green, he was humiliated (i.e., significant life event) in front of 150 people: when putting a point of view across in a meeting, he was told to shut up and sit down. He remarked in his interview that all he wanted was to be understood, as he did not get much understanding from his father (at which point he cried during the interview). The ‘yips’ first occurred on the 18th green at the club where he had been humiliated 6 months previously. The participant indicated that the ‘yips’ were ‘like an electric shock’ going through his left arm as he contacted the ball. He described feelings of embarrassment and humiliation in that he could not perform such a simple task. The participant provided informed consent to undertake the research and institutional ethics approval was granted for the procedures of the study.

**Therapist**

The fifth author delivered the intervention. She had been treating clinical problems for the past 20 years. She was a qualified clinical hypnotherapist as well as a certified practitioner in EFT, but over the past 10 years has only used EFT as her intervention tool. In addition to this, the practitioner had 5 years experience of working with golfers who had been afflicted by the ‘yips’ and was familiar with the concept of treating potential underlying emotional causes. It was deemed appropriate for the independent practitioner to administer the intervention based upon her extensive experience working with similar emotional issues.

**Procedure**

This case study consisted of a baseline measurement, 4 sessions of EFT lasting 2 hr each, interspersed with 4 data collections (collected at Sheffield Hallam University Biomechanics Laboratory). There was a 7-day gap in between each data collection-intervention point. Therefore, the intervention period covered 4 weeks from inception to the 4th and final data collection session. Interventions were started at 12pm and finished at 2pm. In addition, a 6-month follow-up data collection was included so that the longevity of the intervention’s effectiveness could be assessed as previous research has indicated the ‘yips’ can return following the cessation of treatment (Smith et al., 2003). The participant stated that any putt within 6 feet was a potential ‘yips’ putt, therefore the participant was asked to make 10 putts from 2 feet, 4 feet and 6 feet (i.e., total of 30 putts) for each data collection point (i.e., pretest, measure 1, measure 2, measure 3, measure 4 and a 6 month follow-up measure). Before each putt, the golfer was required to make a successful chip into an area of 1 m radius (i.e., a target area around the cup). This was to ensure ecological validity in the laboratory, and to also minimize learning effects between trials. A manipulation check was used at each stage of the intervention to check the therapist was indeed treating the underlying emotional causes identified at the
outset. The manipulation check involved the first author observing the intervention being delivered. The first author was a trained practitioner in Emotional Freedom Techniques so he understood the methods being employed by the therapist and could ensure that treatment of the underlying emotional causes was constantly evident within the sessions.

**EFT Basic Recipe.** The EFT treatment protocol followed the EFT ‘Basic Recipe’ as outlined by its developer (Craig, 1999). This consisted of the therapist tapping on a series of acupuncture points on the participant’s body while the participant remained ‘tuned into’ the problem (e.g., “this negative emotion, this intense distress”) as each acu-point is contacted. The therapist tapped a minimum of seven times in a prescribed sequence, at the end points of the 12 traditional acupuncture meridians (five positioned on the head, two positioned on the upper trunk of the body, and the remaining five on the hand). The participant made a self-accepting statement (e.g., “Even though I was extremely embarrassed when I missed that short putt on the 18th green I deeply and completely accept myself”), which was combined with the therapist rubbing a reflex point in the upper chest known as the “neurolymphatic reflex point” (Callaghan, 1985) before each sequence of tapping in EFT. The treatment continued until all aspects or separate issues of the problem were dealt with (See Appendix A for a description provided by the therapist of the process used in applying EFT to the ‘yips’ for this particular participant).

### Dependent Variables

**Putting Success Rate.** The success rate was determined via a simple scoring system that assigned points relative to the accuracy of the putting stroke (3 points = ball going into the middle of the hole; 2 points = ball going into the hole after hitting the edge of the hole first; 1 point = ball missing the hole after hitting the edge first; 0 points = complete miss of the hole).

**Science and Motion (SAM) Analysis Data.** The SAM Putt Laboratory three-dimensional ultra sonic measurement system was used (Science and Motion GmbH, Munich) for data acquisition of the putting movements made by the participant for 2 feet, 4 feet and 6 feet putts. The system contains a marker triplet with three small ultra-sonic markers, which are clipped onto the club shaft. The position data of the movement paths are stored on a computer and from these position data, face angles, face rotation, path direction, impact spot, velocity, acceleration signals and other information are calculated for further kinematic analysis. For the purpose of this investigation, rotation and velocity of rotation data were analyzed as this indicates the degree of rotation of the club head at impact with the ball. The movement data are presented in Figures 2–4. These Figures provide detailed information on movement competences and deficits. The SAM Putt Laboratory system is accurate to within 1 degree of rotation (Science and Motion GmbH, Munich).
**Visual Inspection Data.** A simple coding system was used to determine the prevalence of the ‘yips’ in the putting stroke (0 = no ‘yips’; 1 = ‘yips’ were prevalent). Visual inspection recommendations by Martin and Pear (2003) were adhered to to establish the occurrence of any experimental effects. These included: (a) crossover of data points between preintervention and postintervention phases, where the lack of overlapping data points supports the effectiveness of the intervention, (b) immediacy of an effect following intervention and (c) the size of an effect after intervention. A fourth recommendation of Martin and Pear (2003) requires a multiple-baseline design to assess the consistency of findings across participants. Unfortunately, this recommendation could not be tested in the present investigation, with only one participant being used in this case study.

**Social Validation**

A social validation questionnaire was administered (see Appendix B). This process was used to assess the participant’s reactions to treatment procedures and experimental outcomes (Pates, Maynard & Westbury, 2001). The social validation questionnaire was designed to provide information concerning the effectiveness of the intervention via the following questions: (a) “How frequently did the ‘yips’ occur today?” with responses ranging from 1 (not at all) to 7 (all the time); and (b) “How severe were the symptoms you experienced today?” with responses ranging from 1 (not severe at all) to 7 (extremely severe). The golfer was also asked two standard open-ended questions at each data collection point about the nature of the treatment and his reaction to the treatment to verify the objective measures taken in these areas. The rationale behind the inclusion of this process was to assess whether any observed changes that occurred during the intervention coincided with improved performance for the participant on the golf course, hence providing some triangulation of the data as well as testing ecological validity. Social validation data were obtained in the participant’s natural performance environment (i.e., playing 18 holes of golf at his Club) before treatments starting, and in between each treatment session, totaling six data collections in all.

**Results**

**Putting Success Rate**

This is the first study to systematically demonstrate the effectiveness of an intervention on a participant’s performance that had suffered from the ‘yips’ (see Figure 1). The results indicated that in comparison with baseline measurement, with the exception of post treatment phase three when putting from 6ft, putting performance at all distances improved following EFT treatment. This trend in improved performance was also maintained at the 6-month follow-up data collection highlighting the longer-term effect of the treatment approach.
Figures 2–4 illustrated graphical reports produced by the SAM Putt Laboratory (Science and Motion GmbH, Munich). The reports displayed rotation data from the putter head from backswing through to forward swing. Furthermore, the reports highlighted the amount of rotation in degrees per second (i.e., velocity of rotation) through the motion of the golf putt, where the black dots on the reports signified ball contact. The general pattern of the results indicated that after each treatment, the ‘yips’ symptoms diminished. At baseline, visual occurrence of the ‘yips’ prevalence was high. This coincided with low levels of putting performance in comparison with later tests (Figure 1). However, by the end of the fourth session of EFT, visual occurrence of the ‘yips’ subsided. In addition, putting performance increased. Furthermore, trial-to-trial variability decreased and the lines on Figures 2–4 (i.e., data collection 4 and 6 month follow-up) illustrate a smoother putting action in comparison with the jerky movement observed at the baseline measurement phases. In addition, this smoother putting action appeared to be retained at the 6-month postintervention follow-up suggesting a positive long-term benefit of the treatment.

Visual Inspection Data

Figure 5 illustrates the improvements that were observed in the visual occurrence of the ‘yips’. Specifically, as each EFT session was completed, the general pattern displayed was that ‘yips’ symptoms subsided. The only occasion where that was not the case was the data at 2 foot and 4 foot during data collection 2.
Figure 2 — SAM motion analysis data for 2 foot putts.
Figure 3 — SAM motion analysis data for 4 foot putts.
Figure 4 — SAM motion analysis data for 6 foot putts.
After the first session of EFT, the participant reported that the severity and frequency had decreased: “Something has changed since the first session of EFT”. After the fourth session of EFT, the participant reported that there was no feeling of the ‘yips’ when out on the golf course. When reflecting on the details of the treatment (i.e., the significant life event), the participant said that he ‘felt something shift’ and that ‘he felt free’ after the EFT treatment had been applied. The participant indicated this improvement took place after the first session of EFT, but it was the continuous applications of EFT that allowed him to feel emotionally clear when thinking about the significant life event.

Improvements in ‘yips’ symptoms observed in the laboratory coincided with the participant’s perceptions of his ‘yips’ symptoms out on the golf course (see Figure 5). The general trend of the data shows that as time went on, symptoms became less severe and less frequent. These findings suggested that the intervention could have impacted positively on the participant’s symptoms.

**Discussion**

The prevalence of the yips is between 32.5% and 47.7% for golfers with a handicap of <10, which is a high proportion of serious golfers (Smith et al., 2000). Therefore, the purpose of this investigation was to test the efficacy of EFT as a treatment for Type I ‘yips’. The results indicated that postintervention, EFT had a direct impact on putting performance. Kinematic data illustrated that at baseline, the participant’s putting stroke displayed large trial-to-trial variability (characterized by sharp peaks
and troughs upon impact with the ball). However, after the fourth session of EFT, variability in the velocity of rotation data had decreased. This was characterized by a smoothing of the lines, which indicated a more consistent putting stroke. The follow-up results suggest that these improvements lasted for a minimum of 6 months post application of the intervention. Post intervention there were no visual indicators of the ‘yips’, whereas at the beginning of the study, a large involuntary twitch could be seen in the participant’s left forearm when striking the ball. Psychological symptoms also seemed to reduce with the participant suggesting he felt ‘more relaxed’ over the ball. Finally, and most importantly, according to the social validation data, these improvements were also observed on the golf course, which provides some indication of the intervention’s ecological validity. Taken collectively, these findings suggest preliminary evidence of the efficacy of EFT as an applicable intervention approach for Type I ‘yips’. Further, and related to the dystonic aspects of Type I ‘yips’ and their associated traumatic causes, the findings support the use of EFT as an intervention strategy for dealing with emotional or traumatic memories (Church et al., 2009; Wells, Polgase, Andrews, Carrington & Baker, 2003).

A secondary aim of this study was to assess whether treating significant life events that were associated with the onset of Type I ‘yips’ would impact positively on ‘yips’ symptoms. The participant had experienced what he termed a significant life event before the development of his ‘yips’. Recent evidence suggests that significant life events may play a role in the onset of various movement disorders. These disorders have been termed psychogenic movement problems (cf., Thomas et al., 2006). A recent study found that out of a sample of 227 individuals who experienced some sort of movement disorder, 33.5% (n = 76) experienced a personal

![Figure 6 — Social validation data: Frequency and severity of ‘yips’ symptoms on the golf course as recorded by the participant.](image)
life stress that preceded the development of the problem, and a further 28.6% ($n = 65$) had also experienced some sort of trauma (Thomas et al., 2006). Similarly, Schweinfurth et al. (2002) indicated that 21% of individuals experienced a major life stress before the onset of spasmodic dysphonia, a disorder very similar to those experienced in occupational tasks. Schmidt et al. (1994) also observed the presence of profound emotional events before the onset of focal dystonia in two women. The fact that Type I symptoms subsided after the EFT intervention in this case study may tentatively suggest that the ‘yips’ are a form of psychogenic movement disorder. It could be that ‘yips’ at the dystonic end of the continuum are caused by the occurrence of psychologically significant life events. This could help explain why athletes often perceive their ‘yips’ to have occurred out of the blue, as the physical symptoms often occur in close proximity to the significant life event (Bawden & Maynard, 2001).

The exact mechanisms underpinning psychogenic movement disorders are unclear. However, the disturbances have been attributed to dissociation theories and conversion disorders (Baker & Humblestone, 2005). It could be that the physical symptoms the performer experiences in Type I ‘yips’ are a defense mechanism to prevent individuals from accessing the significant event. Furthermore, it could be that certain environmental stimuli are present that initially stimulate the ‘yips’. The golfer in this study highlighted an event where he had been humiliated in a meeting overlooking the 18th green at his Club. This event took on significance given the fact that the ‘yips’ occurred for the first time on the 18th green in his first game following the traumatic meeting, although some six months later.

An alternative explanation for the development of the problem may be provided by recent advances in neuroscience, specifically revolving around the role of the amygdala. The amygdala is a limbic system structure that is involved in many of our emotions, particularly those that are related to survival. The amygdala is responsible for determining what memories are stored in the brain. It is thought that this determination is based on how significant an emotional response the significant life event evokes (Stokes, 2009). Stokes (2009) suggested that when an individual is exposed to a situation that the amygdala perceives is threatening, it codes the event in three ways (i.e., emotion, image and belief), thus forming an amygdala script. When the emotional, image or belief components are activated through perception, the amygdala is activated in the same way as it responded in the initial event. It could be that Type I ‘yips’ is simply the activation of an amygdala script and is serving to protect the individual through its survival mechanism.

The debates around the central causes of the ‘yips’ remain ongoing, but what is particularly of interest here is the role EFT has played in reducing Type I ‘yips’ symptoms. In light of the fact that EFT is derived from acupuncture theory, EFT may have helped produce these results through intervening in the body’s so-called energy system (Wells et al., 2003). Evidence showing a marked difference between acupuncture points and nonacupuncture points in terms of electrical resistance of the skin (Cho, 1998; Sylotna & Rein, 1999) is, in turn, consistent with the notion that the meridian based therapies may derive their special therapeutic properties from stimulating specific acu-points (Gallo, 1999). A second explanation could be that EFT constitutes a novel form of desensitization (Wells et al., 2003). Wells and colleagues noted that since EFT requires focusing of attention upon a feared object while tapping, this combination of repeated focusing while the performer is relaxed
may desensitize the client to the effects of anxiety. The positive benefits of EFT have also been attributed to a number of other more conventional psychobiological mechanisms such as: decreased hyper-arousal of the limbic system and other brain structures involved in the fight-or-flight response generated by exposure to trauma (Feinstein, 2008) and changes in the amygdala and anterior cingulate areas of the brain (Felmingham et al., 2006). If the latter is true, it could be that EFT allows the amygdala to recode events as less threatening, thus resulting in a de-activation of any amygdala scripts that were previously activated through the emotional, image or belief components (Stokes, 2009).

An additional explanation might be down to the experience of the practitioner used in the current study. The practitioner had over twenty years experience of dealing with clinical problems, where her background originated from clinical hypnotherapy. In addition to this, the practitioner also had five years experience of working with golfers who experienced the ‘yips’. The practitioner was aware of underlying emotional problems before the development of the ‘yips’ through her clinical experience of treating individuals with the problem. While checks were made that the practitioner followed the EFT treatment method, it is suggested a certain amount of intuitive work took part once the initial problem was explored, and the separate ‘aspects’ of the problem emerged (Grand, 2001). The analogy of peeling an onion best describes this process. Once the initial layer was removed (i.e., the humiliation experienced by the golfer), separate skins emerged that needed to be removed before other skins became prevalent. While it was suggested at the outset that the practitioner would work solely on the issue presented, it was clear that separate life events also linked in with the presenting issue. Future studies need to address the issue of expertise in the delivery of EFT as an intervention to treat the ‘yips’. It could be that those seeking treatment for their ‘yips’ need to use practitioners with a certain level of expertise, either through their understanding of the mechanisms that can potentially lead to the onset of the ‘yips’ or through an appropriate understanding of working with similar clinical issues. Likewise, it could be that anyone who has a basic understanding as to how EFT is applied could work with the ‘yips’.

Certainly, the theory of EFT would be better understood if future studies can incorporate experimental control conditions such as ‘random tapping’ groups. By comparing a random tapping group, versus EFT and an appropriate control condition, it would then become evident whether indeed EFT obtains its results in the body’s so called energy system (Wells et al., 2003). Further support for the role of EFT may be gained by measuring physiological changes (e.g., EEG, heart rate), which occur in relation to each point being tapped. This would provide preliminary evidence as to the mechanisms underpinning the process.

It is clear that the current study has shown EFT to be a potentially effective treatment intervention. It is vitally important that future investigations explore the role of EFT compared against other modes of intervention such as CBT, counseling, or psychoanalytical therapy. In addition, future investigations should try and control for the levels of expertise of the practitioner dealing with the problem. The one advantage EFT is claimed to have over several other therapies is the speed at which it removes negative emotional states (Wells et al., 2003). Certainly, in the case of the investigation presented here, it would appear that the intervention has impacted Type I ‘yips’ symptoms in a short space of time. However, it would be
irresponsible to claim that this intervention is quicker or more effective than other modes of therapy until appropriate control and comparison conditions are used, with larger and more representative samples.

References


Appendix A –
Practitioner Epilogue

I have been treating individuals with the ‘yips’ for the past 5 years and the method of delivery I have developed comes largely from my work as a clinical hypnotherapist. There are some common threads to how I work, and the method I use.

The first and most important step for me when working with individuals experiencing complex issues such as the ‘yips’ is to build a rapport with them. I try to ensure that the environment I provide is nonjudgmental. Over the years, I have learned that the key to resolving the root issue of many of these problems is getting people to open up. They have to have absolute trust and faith in my skills as a practitioner that, firstly I will not judge what they are saying (often, what comes up can be highly embarrassing from their perspective), and secondly I am there to genuinely help them overcome their problem. I believe the fact that I am female helps this process, as I am working with people’s egos within this process. They do not want to be judged.

Once rapport is established, I begin with the question ‘At or around the time the ‘yips’ started, was anything going on in your life’? I usually work within a two-year time frame from when the ‘yips’ started. For the golfer we were treating, it was clear that the meeting (AGM) was a significant moment for him. It was at this point I started applying the EFT basic recipe to this emergent issue. From this point onwards, it was about asking the right questions at the right time. The key is to find out what the story is, and how the issues link together as to why the ‘yips’ started at that specific time. In the case of our golfer, there were numerous aspects of the problem that were linked to the AGM incident. But, at the very root of the problem, which is where I try to get to, the AGM triggered a specific point in time for the golfer. The feelings of embarrassment, being judged and wanting to be understood were hugely significant in this specific instance. When he came out to play golf again 6 months after that incident, his ‘yips’ started on the 18th green, the green that overlooked the clubhouse where the AGM had been held. I apply the EFT basic recipe to all of the aspects that emerge, but my role in the intervention is to ensure that I find out what the story is, what the golden threads are that link things (e.g., in this case feeling exposed) together, and how this all links to the ‘yips’ emerging at a specific time and place. These triggers can be something someone has said, they can be an image, or it can be a situation that has the potential to reproduce the emotional experience they associate with the problem. For this client, the key elements of the problem where the 18th green, the AGM, and the experiences this reminded him of.

Between each of the EFT sessions delivered, I asked the golfer to keep a check of anything else that emerged in relation to the ‘yips’, and systematically applied the EFT process to any issues raised. Usually, once they are back on the golf course, it can stimulate certain thoughts or feelings again. Anything, which is significant, we work through again, and we try and work out how this all fits to the story or picture we are trying to build. I also asked the golfer to tap on any issues that they felt emerged while on the golf course. Once I am confident that all of the issues have been cleared which contributed to the ‘yips’ starting, I then apply the EFT
basic recipe to the most significant ‘yips’ episodes the person has experienced, and the physical and psychological symptoms they can remember. I have tried working with just the symptoms in the past, but I have found this has minimal impact. You have to root out the causal mechanisms to clear the ‘yips’ long-term. It is at this point that the individual is clear from their ‘yips’.

Lynn Francis, 5th Author
Appendix B –
Social Validation Questionnaire

1. How frequently did the ‘yips’ occur today?

<table>
<thead>
<tr>
<th>Not at all</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>All of the time</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
</table>

Please provide some context for your answer in this box

2. How severe were the symptoms you experienced today?

<table>
<thead>
<tr>
<th>Not severe at all</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>Extremely severe</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
</table>

Please provide some context for your answer in this box