

選擇題：共 20 題，每題 2 分，請在答案卡上依序作答

1. 下列對精神分析治療的描述，何者正確？ ①重視與個案建立不受過去經驗汙染的真實關係 ②主張治療師的反移情是重要的治療工具 ③認為處理阻抗最好的方式就是繞過阻抗 ④強調以詮釋技巧揭露個案的潛意識。(A)②③④ (B)①②④ (C)①③④ (D)②④。
2. 下列對諮商關係的描述，哪些正確？ ①行為治療主張治療關係是建立治療策略的根基 ②現實治療要求諮商師與個案建立參與的(involvement)關係 ③精神分析治療關注移情關係的發展與詮釋 ④女性主義治療主張關係本身即可帶來個案的改變。(A)①②④ (B)①③④ (C)①②③ (D)①②③④。
3. 下列對心理發展理論的敘述，何者正確？ ①佛洛伊德與艾瑞克森都認為 0-1 歲是建立對人信任的重要階段 ②佛洛伊德提出的伊底帕斯情結與艾瑞克森主張自卑產生的時間是在同一個發展階段 ③艾瑞克森認為佛洛伊德的性心理發展理論忽略社會文化的影響力 ④佛洛伊德認為 1-3 歲階段，父母對幼兒排便訓練的方式將形塑其人格。(A)①③④ (B)①②④ (C)②③④ (D)①②③。
4. 「芳芳」在男朋友主動提出分手之後，感到相當悲傷與痛苦，然而她卻一直說服自己，「男朋友並不是真的想與她分手…自己應該還有機會…有一天男朋友還是會發現自己是最適合他的人…」？請問芳芳使用了哪一種防衛機制 (A)分裂 (B)否認 (C)融合 (D)迴攝。
5. 下列對諮商技術的描述，何者正確？(A)存在主義治療主張以系統性技術提升個案對個人存在議題的察覺 (B)理性情緒行為治療主張運用讀書治療協助個案學習認知與情緒的關係 (C)完形治療主張以預先為個案量身訂作的治療策略協助個案接觸現實 (D)性別雕塑是女性主義治療常用的技術。
6. 下列何者是阿德勒治療在探索個案心理動力時評估的項目？ ①早期回憶 ②認知形態 ③成功經驗 ④優先選擇。(A)①② (B)③④ (C)②③ (D)①④。
7. 下列對家族治療的描述，何者錯誤： ①主張系統具有抗拒改變的特徵 ②從個人的內在系統檢視問題 ③家族系統治療是具有高度理論與技術整合的取向 ④主張個人的症狀一定與家庭系統有關。(A)①②③ (B)②③④ (C)①③④ (D)①②③④。
8. 下列配對，何者正確？ ①克萊恩(Klein)－投射認同 ②貝克(Beck)－非理性信念 ③包文(Bowen)－三角關係 ④艾里斯(Ellis)－自動化想法。(A)①② (B)③④ (C)②④ (D)①③。
9. 下列哪些治療理論特別重視個案夢境材料的運用與處理？ ①分析取向治療 ②認知行為治療 ③女性主義治療 ④精神分析治療。(A)①② (B)③④ (C)②③ (D)①④。
10. 下列對諮商理論與治療實務的描述，哪些正確？ ①阿德勒治療會協助個案探索私人邏輯 ②存在主義治療會協助個案降低存在性焦慮 ③女性主義治療會使用閱讀材料協助個案增長知識 ④焦點解決治療

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會致力於協助個案探索問題根源 (A)①② (B)①③ (C)①②③ (D)①③④。

11. 關於心理劇之論述, 下列敘述那些是正確的? ①輔角可以幫主角說出平常溝通時未能表達之情緒或想法 ②用身體活動 (physical activity) 導入非語言的溝通 ③用未來投射法 (future projection technique) 來協助案主培養對他人的同理 ④角色距離來幫助案主重新界定其所處之狀況, 並重新調整對他人之期望 (A) ①②④ (B) ②④ (C) ①③ (D) ①③④

12. 近年來越來越強調要成為有效的多元文化諮商實務工作者, 下列敘述何者明顯不屬於多元文化諮商之概念? (A) 諮商師能覺察自己的內在信念、價值觀與態度對諮商之影響 (B) 諮商師對案主的問題要由其社會文化脈絡去找, 而非由個人內在去了解 (C) 諮商師需在文化敏感度及刻板印象之間取得平衡點 (D) 諮商師需增加對於文化影響的反省能力

13. 下列那一組配對是正確的? (A) 瑜珈靜坐 (Yoga Meditation) - 強調人格的改變必須從身體柔軟度的改變開始 (B) 森田療法 (Morita therapy) - 重如其所是的接受現實 (C) 內觀心理治療 (Naikan psychotherapy) - 教導案主接納並重新詮釋其所擁有的症狀 (D) 生物量能分析 (Bioenergetic Analysis) - 在症狀下仍如常行動, 為所當為

14. 關於家族治療之概念, 下列那些敘述是正確的? ① Minuchin 與 Haley 均強調重組家庭階層 (hierarchies) 或次系統 (subsystems) ② Whitaker 強調在家庭中促進自發性 ③ Bowen 強調滋養的三角關係 ④ Satir 以家庭雕塑 (family sculpting) 技術來讓案主體驗家人之關係、互動等 (A) ①② (B) ①③ (C) ①③④ (D) ①②④

15. 關於焦點解決學派 (solution-focused brief therapy, SFBT) 的諮商過程與技術, 下列敘述何者正確? (A) 抱怨者 (complainant) 是別人要他來諮商, 他不認為自己有問題的 (B) 以外化問句 (externalizing questions) 來幫案主了解其困擾 (C) 使用「一般化」(normalize) 技巧來減低個案的恐懼/擔心 (D) 以例外問句協助案主找到自己的問題癥結

16. 丈夫抱怨妻子嘮叨不休, 諮商師會說她(妻子)是爲了想和丈夫變得更爲親密, 這是運用什麼技巧? (A) 考驗治療 (ordeal therapy) (B) 行動重現 (enactments) (C) 重新框視 (reframing) (D) 雙重束縛 (double bind)

17. 關於生涯諮商的論述, 下列敘述何者正確? ① Holland 理論界定生涯興趣爲 RIASEC 六大類型, 其中的 E 係指實用型 ② 評量個體職業世界認識結構的最佳方法是職業組合卡 ③ 生涯幻遊技術有助於個案處理其抗拒作用 ④ 決定平衡單在生涯諮商中常用來協助當事人有系統的分析與評價每個可能的選項 (A) ②④ (B) ①③ (C) ①②③ (D) ②③④

18. 下列有關存在主義取向治療之敘述何者爲正確的? ① 重視治療者與案主的共同旅程 ② 認為人格的內在衝突是來自於早期重要他人的要求 ③ 焦慮是一種生活的狀態是他們對人性的重要命題之一

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④對死亡的覺察，能促使人們去探求生命的意義 (A)①③④ (B)②③ (C)①④ (D)①②③

19. 下列有關認知行為治療之敘述那些正確？①Beck 的「認知三角」是指對自己、他人及世界的認知
② Meichenbaum 的認知行為修正法 (cognitive-behavior modification) 主要是運用認知重建原理，以改變當事人內在語言 ③認知行為取向的共通特性是較偏教導、有時限且聚焦於特定結構性問題 ④

Beck 比 Ellis 常用蘇格拉底式對話。(A)①②③④ (B)②③④ (C)②③ (D)③④

20. 下列技巧那些是女性主義治療 (Feminist Therapy) 常用的？①性別角色分析 (gender-role analysis)

②自我揭露 (self-disclosure) ③讀書治療法 ④ 外化式的對話

(A)①③④ (B)②③ (C)①② (D)①②③

二、申論題：共 3 題，每題 20 分，請標示題號並依序作答 非選擇題請用答案卷作答

(一)對於尋求心理諮商的當事人，諮商師旨在協助其「改變」，雖然不同諮商理論對於所謂的改變各有不同的看法，然而在協助個案改變的過程，經常會遭遇到個案抗拒的力量。請問，你個人對個案抗拒改變的觀察是什麼？(5 分) 試從諮商理論申述在協助個案改變的過程中，你會如何處理個案抗拒改變的問題？(15 分)

(二).近年來行為學派有發展出下列幾個新的取向

a.辯證行為治療(Dialectical behavior therapy (Linehan, 1993a, 1993b)

b.正念減壓療法(Mindfulness-based stress reduction, Kabat-Zinn, 1990)

c.正念認知療法(Mindfulness-based cognitive therapy ,Segal et al., 2002)

d.接受及承諾治療(Acceptance and commitment therapy, Hayes, Strosahl, & Houts, 2005; Hayes, Strosahl, & Wilson, 1999)

請說明其特色為何?(10 分)它們和傳統行為學派的差別在那裏? (10 分)

(三).請閱讀下列文獻資料後，回答問題

請摘要敘述本文之重點。(10 分)

請說明你對本文作者論點之贊同及反對之想法。(10 分)

請用中文作答，且有專業術語時，請在後面用括號註明英文，以供對照。

Perfectionism and cognitive-behavioural theories of maintenance of disorders

Shafran et al. (2002) have devised a model of “clinical perfectionism” that is designed to describe how perfectionism might maintain a variety of psychopathologies. Clinical perfectionism has been defined as “...the overdependence of self-evaluation on the determined pursuit of personally demanding, self-imposed, standards in at least one highly salient domain, despite adverse consequences”.

A recent revision of the model (Shafran, Egan, & Wade, 2010) as seen in Fig. 1 makes explicit the role that performance related behaviour, including performance checking (e.g., constantly comparing performance to others), avoidance, procrastination, and counterproductive behaviours (e.g., being over-thorough, checking) has in maintaining the cycle of clinical perfectionism. Preliminary data are consistent with the model. For example, individuals with perfectionism 'raise the bar' after achieving their goals (Kobori, Hayakawa, & Tanno, 2009) and dichotomous thinking, does predict significant variance in perfectionism (Egan et al., 2007). A qualitative study has also supported the maintaining factors of the model, for example finding themes of self-criticism following failure, rules, rigidity and avoidance amongst individuals with clinical perfectionism (Riley & Shafran, 2005). There is also data supporting that self-oriented and socially-prescribed perfectionism is associated with higher levels of shame and guilt following failure in a task, which supports predictions of the model (Stoeber, Kempe, & Keogh, 2008).

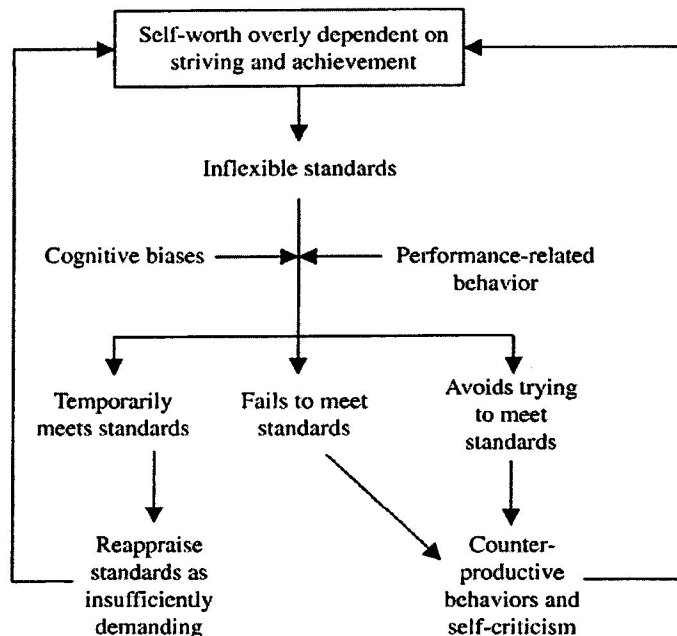


Fig. 1. The revised cognitive-behavioural model of clinical perfectionism, reproduced from Shafran, Egan, and Wade (2010).

Furthermore, criticisms of the model (e.g., Dunkley, Blankstein, Masheb, & Grilo, 2006) are based on the notion that Shafran et al (2002) were stating that personal standards were maladaptive. However this is not the case, rather the underlying idea in the model of clinical perfectionism was that there was nothing maladaptive in striving for excellence in itself, rather it is when someone bases their sense of self-worth almost exclusively on striving for standards, and concern over mistakes in meeting these standards, when perfectionism becomes a "clinical" problem. Thus, findings in the literature supporting two main areas of perfectionism involving Personal Standards and Maladaptive Evaluative Concerns (Dunkley, Blankstein, et al., 2006), are in line with the model of clinical perfectionism, where the emphasis is on the maladaptive nature of basing self-evaluation on striving, and concern over mistakes in striving.

Treatment of perfectionism

Assessment and individualised case conceptualisation

It is suggested that clinicians routinely assess for perfectionism, through the use of the MPS scales and also by focusing on issues identified in the model of clinical perfectionism shown in Fig. 1. This would entail that clinicians ask about the degree to which their patient bases their sense of self-worth on striving and achievement. If the patient judges their self-worth predominately on how well they achieve their personal standards, then it is important to further assess for the maintaining factors of clinical perfectionism. These are

outlined in the revised cognitive-behavioural model of perfectionism in Fig. 1. This involves asking the client what areas of their life they have high standards in and the impact that striving has on their life. Examples of their reaction to failure to meet a goal, whether they feel satisfied after reaching a goal, and if they re-set their standards higher after meeting a goal or avoid trying to meet a goal because of fear of failure (i.e., procrastination) are explored. Cognitive biases are assessed by determining their dichotomous rules for achievement, and how they react to breaking their rules. Examples to determine whether they discount their successes and notice their failures are detailed. To assess self-criticism, a recent example of their cognitions when they made a mistake is explored. Counter-productive behaviours are assessed through asking the patient what they avoid and delay in regards to performance, examples of how they compare their performance to others, and if they seek reassurance from others about their performance. This information is used to guide the development of a collaborative, individualised, formulation diagram for the patient based on their examples, following the diagram in Fig. 1.

Directly target perfectionism early in treatment

If a clinician identifies that perfectionism is elevated in their patient and that it is substantially interfering with their quality of life, then it should be focused on specifically and addressed adequately and directly in treatment. This may involve directly targeting perfectionism as the primary issue, particularly if it appears to be a barrier to change with an established intervention. Techniques to treat clinical perfectionism have been described in detail elsewhere (Shafran et al., 2010). Briefly, strategies include increasing motivation to change and self-monitoring of the maintaining mechanisms in the clinical perfectionism model. To address counter-productive behaviours and rigid rules, surveys and behavioural experiments are utilised. Cognitive biases including dichotomous thinking and selective attention are addressed through thought records, behavioural experiments and continuums. Self criticism is addressed through thought diaries and utilising a compassionate rather than critical voice. Finally, broadening self-evaluation is achieved through pie charts to consider other aspects through which a patient can evaluate their self-worth instead of predominately by achievement.

The aim of treatment is not to remove striving for personal standards or lowering standards, rather to remove self-evaluation being exclusively based on meeting personal standards, and criticism when the standards are not met. This may result in altered standards that contribute to a better quality of life. It has been argued that it is adaptive to reduce energy when a goal cannot be met, and to relinquish goals if they are unattainable, as continued commitment to a goal that is not able to be met leads to distress (Carver, 2004; Johnson, Carver, & Fulford, 2010). Consequently, we might consider someone to be recovered from clinical perfectionism when they are able to still strive towards goals that are attainable, to not judge themselves adversely if the goals are not met, to invest energy in goals that are not performance related, and to be able to shift focus and effort away from unattainable goals. Based on Perceptual Control Theory, Mansell (2005) has described how distress is created by individuals having a conflict between goals, for example a striving towards and avoidance of goals at the same time (see also Mansell, Harvey, Watkins, & Shafran, 2009). Within this model of normal goal striving, we may consider an individual to have recovered from clinical perfectionism if they are able to resolve the conflict between their goal states of striving towards and avoidance.

上文摘自 Egan, S. J., & Wade, T. D., Shafran, R. (2011). Perfectionism as a transdiagnostic process: A clinical review. *Clinical Psychology Review*, 31, 203-212.