國立交通大學97學年度碩士班考試入學試題

：輔導與諮商(6093)　　考試日期：97年3月8日 第3節

班別：教育研究所　　組別：教研所乙組　　

答前請先核對試題、答案卷(試卷)與准考證之所組別與考科是否相符！！

一、選擇題：共20題，每題2分，請標示題號並依序作答

1.下列對我國學校輔導工作發展概況的說明，何者正確(1)大學輔導工作是各層級學校輔導工作的濫觴 (2)指導活動室是高中輔導室的前身(3)大學輔導工作起源於僑生輔導 (4)小學輔導制度至今尚未建立。

2.下列何者不是心理師法中載明之諮商心理師執業範圍？(1)社會適應偏差之心理治療 (2)一般心理狀態與功能之心理衡鑑 (3)精神病之心理治療 (4)心理發展偏差之心理治療。

3.對中輟學生的回校輔導屬於哪一種輔導服務？ (1)諮詢服務 (2)衡鑑服務 (3)延續服務 (4)定向服務。

4.下列何者是成為具多元文化敏感度的團體領導者最首要的基本條件？(1)檢視自己身為人與諮商師的文化脈絡、價值體系與信念系統 (2)具備對各種文化充分完整的認知 (3)充實適用於不同文化種族的團體帶領策略與技巧 (4)認可自己身為團體領導者的各種限制。

5.下列何者是自我涉入技巧與自我揭露技巧的主要差異？ (1)揭露的內容 (2)揭露的深度 (3)揭露的目的 (4)揭露的時機。

6.下列哪一個技巧使用過當，容易造成表面的問題解決？ (1)面質 (2)建議 (3)解釋(4)回饋。

7.下列何者是判斷雙重關係適當與否的最重要考量因素？(1)雙重關係能否避免(2)雙重關係對治療關係的影響 (3)諮商心理師對雙重關係的覺察能力 (4)諮商心理師對角色權力的使用情形。

8.曉清一直向友人哭訴她先生對她造成的傷害，曉清卻一點也不生氣，反倒是她的朋友為她感到極為氣憤，原本應該是曉清的感覺卻跑到朋友身上。在這個現象中，請問曉清使用了哪一種防衛機制？(1)分裂(2)投射(3)合理化 (4)潛抑。

9.Freud認為哪一個階段是學習紀律最重要的階段？(1)口腔期 (2)性蕾期 (3)肛門期(4)潛伏期。

10.Perls以剝洋蔥比喻人格探索過程，他認為5個精神官能症的層次須在諮商中逐一脫去，下列哪一個順序的描述正確？(1)虛假－僵局－內爆－恐懼－外爆 (2)虛假－內爆－僵局－恐懼－外爆 (3)虛假－內爆－僵局－恐懼－外爆(4)虛假－恐懼－僵局－內爆－外爆。

11.完形治療中夢的理論之核心概念為？(1)投射 (2)詮釋 (3)角色扮演 (4)歷程評論。

12. Ellis對理性信念特徵的描述，何者不正確？ (1)彈性的 (2)客觀的 (3)合邏輯的 (4)促進目標達成的。

13. 下列對存在主義治療的敘述何者正確？(1)強調技術的使用 (2)強調每個人自由有限，因此無法為自己存在的方式負完全的責任 (3)認為人只要勇於面對自己就不會感到存在的焦慮 (4)關切人類存在的深層經驗。

14. 阿德勒學派在評估階段詢問個案，「你跟哪一個兄弟姐妹感情最好？」，請問這個問句主要在蒐集哪一部分的資料？(1)生活型態 (2)家庭星座 (3)早期回憶 (4)優勢人格。

15. 下列對家族治療的描述何者錯誤(1)自我分化是 Whitaker 理論的核心概念 (2)結構派家族治療的目標是改變界線不清的代間關係 (3)Satir 的治療目標是改變家庭的溝通型態(4)社會建構取向重視將問題外部化。

16. 以下何者是個案概念化的內容？(1)收集案主問題的相關資料，形成問題的假設與診斷 (2)受督導者與督導者藉由角色扮演的方式，演練某次諮商情境的過程 (3)形成諮商介入的策略與處遇計畫 (4)瞭解案主與諮商師的互動關係及其影響

17 嘉雄無法理解為什麼太太會對他有那麼強烈之情緒，團體帶領者，就請一位成員模仿其與家人互動的語言、非語言的姿勢、態度等，讓嘉雄在旁邊觀看，這是心理劇的什麼技巧？(1)金魚缸技術 (2)重現技術 (3)角色轉換技術 (4) 鏡照技術

18. 明德就讀國二，近來為了買名牌包給女友，晚上去幫忙賭場把風，且有抽煙及打架等偏差行為，因而不斷和父母親產生衝突，經由會談發現這個家庭有一隱憂，擔心明德會步其父親喝酒及賭博之後塵，誤入歧途。諮商師可以在家庭諮商方面著力的有那些? ①要明德多為家人著想，不要一直有偏差行為 ②挑戰家人災難預期的認知 ③鼓勵明德找到自己之方向及促進家庭真誠的互動 ④邀家人來談，並讓他們看到家庭生活周期中，過去的歷史腳本帶來之影響 (1)①②④ (2)②③④ (3) ①②③④ (4) ③④

19. 焦點解決短期諮商（solution-focused brief therapy）在第一次及第二次晤談之間，會要個案作一個家庭作業，去觀察自己想要的在這期間有否發生，這技巧之名稱為何? (1) 未來投射法(future projection technique) (2) 建橋(bridge)技術 (3) 第一次晤談處方(formula first session task) (4) 行動重現（enactments）技術

20. 關於敘事治療法（narrative therapy），下列敘述何者錯誤？ (1) 解構強勢的敘述，重新改編生活 (2) White 藉由行動重現(enactments)增加當事人看清楚影響他的外在問題是什麼 (3) 諮商師「不知」的位置促成了諮商師之參與者-觀察者及過程催化者的角色 (4) 透過問話(questions)檢視主流文化之影響及將自己與問題分開

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二、 申論題：共 3 題，每題 20 分

(一). 假設你在某一大學諮商輔導中心擔任諮商心理師的工作，你於早上接到中心主任的通知，表示某科系大二學生昨夜在宿舍自殺身亡，主任希望你接手負責處理這個校園危機。請問危機處理的概念為何？(5 分)你會如何著手處理這個校園危機事件？(15 分)

(二). 諮商要有效果常與能否與個案建立良好諮商關係有密切關係，請就存在治療、認知行為治療、平權主義、敘事治療等四大諮商理論對諮商關係的看法，加以說明與比較(12 分)；最後提出你個人與個案要建立良好的諮商關係需要把握那些重點（8 分）。

(三) 請閱讀下列文獻資料後，回答問題

How do cognitive and behavior therapies produce their enduring effects? Cognitive Theory (CT) suggests that change in what people believe and the way they process information is the primary mechanism of change in CT (Beck 1991). Several studies have shown that thinking does change over the course of therapy; however, the kinds of "surface-level" automatic negative thoughts found in the stream of consciousness typically change as much in pharmacotherapy or other successful interventions as they do in CT (Imber et al. 1990, Simons et al. 1984). What does appear to change in a more specific fashion are the underlying beliefs and information-processing propensities often found in depression, such as core beliefs about the self or the way an individual explains the causes of negative life events. Such core beliefs and information-processing styles tend to lie dormant until activated by negative affect or external stress and serve as the stable cognitive predispositions in a larger diathesis-stress model of depression (Hollon et al.1992b).

For example, in an earlier trial, we found that CT and medication treatment produced comparable rapid change in depression, with 90% of the symptom change occurring in the first six weeks treatment (Hollon et al. 1992a), but that patients treated to remission with CT were only half as likely to relapse following treatment termination as were patients treated to remission with medications (Evans et al. 1992). Change in "surface-level" automatic negative thoughts such as a sense of hopelessness was nonspecific with respect to treatment modality and mirrored the rapid rate of change shown by depressive symptoms, although it did predict subsequent change in depression to a greater extent in CT than in medication treatment (DeRubeis et al. 1990). At the same time, patients treated to remission with CT showed considerably greater change in underlying attribution style (the way they explained negative life events), and the bulk of that differential change occurred in the second half of treatment, well after the bulk of change in depression (Hollon et al. 1990). Moreover, this differential change in attribution style predicted the greater rate of relapse in the patients treated with medications alone relative to CT following treatment termination. Change in these more stable information-processing proclivities mediated the enduring effects of cognitive and behavior therapy (CBT) in a sample of at-risk young adults

provided with a preventive intervention (Seligman et al. 1999). Taken together, these findings suggest that change in cognition mediates the enduring effect found for CBT, but it is change in stable cognitive predispositions and underlying information-processing proclivities that is key to prevention.

We do not yet have a good sense as to whether these changes reflect true accommodation in underlying cognitive predispositions or the acquisition of compensatory mechanisms, since existing measures are susceptible to either process (Barber &DeRubeis 1989). Anecdotal reports from patients suggest that it is more the latter, at least at first, as they describe needing to remind themselves to engage in formal cognitive restructuring techniques when they start to interpret negative life events in a problematic manner. Nonetheless, these same patients describe these capacities as becoming more automatic over time, such that they are less likely to jump to negative conclusions, a process more in keeping with the notion of accommodation. This area merits further investigation.

Finally, Tang&DeRubeis (1999) have observed that many patients treated with CT show "sudden gains" following a single session that account for the bulk of the change they show across the course of treatment. These sudden gains occur at different times for different patients, but tend to be preceded by cognitive change and followed by improved ratings of the therapeutic alliance. In effect, it is as if the patient suddenly "understands" that their thinking is unduly negative, rather than their personalities that are flawed or even their life situations that are to blame. Once they come to this realization, they seem to do a better job of managing their own affect and behavior. Patients who show sudden gains tend to get better faster and to stay better longer than do patients who show a more gradual pattern of response. At the same time, process studies indicate that attention to specific concrete beliefs and behaviors early in treatment leads to greater subsequent change in depression and higher ratings of the quality of the therapeutic relationship (DeRubeis & Feeley, 1990, Feeley et al. 1999). Taken in aggregate, these findings suggest that patients are most likely to show enduring change when their therapists focus on specific behavioral and cognitive strategies in a structured manner, but that this change is likely to emerge in a rapid and unpredictably idiosyncratic fashion across patients.

(1). 請摘要敘述本文之重點(10 分)

(2). 請說明你對本文論點贊同及反對之想法。(10 分)

請用中文作答，有專業術語時，請在後面用括號註明英文，以供對照。