令和 7 年度入学者選抜試験問題

英 語（後期日程）

（注 意 事 項）

1．試験開始までに表紙の注意事項をよく読んでください。

2．試験開始の合図があるまで、この冊子を開いてはいけません。

3．試験開始の合図があったら、すぐに用紙の種類と枚数を確かめ、受験番号を答案用紙に記入してください。

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- 答案用紙（英語その 13）～（英語その 16） 4 枚　計 17 枚

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6．試験終了後、答案用紙を回収します。上から答案用紙（英語その 13）～（英語その 16）の順に、おもて面を上にして半分に折った状態で用紙の上下をそろえて 4 枚重ねてください。

7．表紙および問題用紙は草案として使用してもかまいませんが、採点対象とはしません。必ず持ち帰ってください。

8．すべての確認作業が終了するまで着席していてください。

令和 7 年度入学者選抜試験 問題用紙（英語その1）　— 後期 —

問題 1 次の文章を読み、筆者の主張を踏まえて以下の問に答えてください。

The Greek word τέχνη, '*techne*', which is usually translated as 'art', 'craftsmanship', 'knowledge', or 'skill', is generally used to designate the creation of something. In ancient philosophy, however, *techne* was not just perceived as an activity, but above all as a kind of knowledge. For Plato(1), who was the first to elaborate on this concept in writing, *techne* and episteme(2), art and knowledge, were closely related. Also for Aristotle(3), *techne* was a kind of knowledge that goes with a certain form of creative activity. According to him, the goal for the individual craftsman is to achieve as perfect an imitation of nature as possible – although he was well aware of the impossibility of creating exact copies. *Techne* in this classic sense – and this cannot be emphasized enough when comparing ancient and modern technology – is basically focused on individual work instead of on the streamlined production of many objects of the same kind in order to make a profit. Mass production would be inconceivable to the ancient craftsman, and not just for technical reasons.

It is an interesting and often overlooked fact that technological innovation flourished during the Middle Ages, between about 500-1500 AD. A great number of inventions saw the light of day then: not only gunpowder and the printing press, but also the compass, new plows, spinning wheels, water wheels, and other machines… But all these inventions, which would all radically change the world, were kept within the craftsman's limited world, and the leading philosophers did not generally care to reflect on such matters. One exception was Francis Bacon (1561-1626), who, among other things, was a philosopher who had technology as a central theme. By his claim that 'knowledge is power' he meant that people, through knowledge of nature and the practice of technological power over it, could create a rich and prosperous society, even an ideal one. And in the early seventeenth century, the view on technology started to change fundamentally. At this point modern natural science began to see the light of day.

The leading character in this scientific revolution is Galileo Galilei (1564-1642). Galileo examined reality outside of old scholastic dogmas or authority, and, with scientific experiments, sought to uncover its secrets. He expanded science with, among other things, the new telescope he hand-made, making it possible for humanity to look further into space than ever before, discovering that Jupiter had four moons orbiting it and that our own Moon had craters and mountains. After he died, physicians and astronomers, physicists and philosophers, began to work according to his principles. They weighed, measured, counted and designed a variety of ingenious instruments to help them do so. René Descartes(4) (1596-1650) sketched a universe in which inexorable(5) mechanical laws prevailed. Eventually, by the end of the seventeenth century, scientific development was crowned with Isaac Newton's (1642-1726) grand philosophy of nature, in which he used the principles of mechanics to describe the world as a great machine. Newton's philosophy of nature became known as 'mechanical philosophy'. We might say it set the scene for philosophy about technology.

New technology evidently goes hand in hand with the scientific revolution. But the leading philosophers of the seventeenth and eighteenth centuries had little substantial to say about it. It was generally believed that technology was applied science and that it was entirely in the service of the good. Indeed, at this point in history, the view was almost entirely technophilic and optimistic. In the early 1800s this vision was expressed, albeit in different ways, by G.W.F. Hegel(6) (1770-1831) and Auguste Comte(7) (1798-1857). Hegel described the self-realization of the spirit of the world through reason in works such as the *Phenomenology of Spirit* and *Elements of the Philosophy of Rights*, which came to hold great importance for the emerging philosophy of technology. Comte, an engineer by trade, dismissed Hegel's speculative metaphysics(8), choosing instead to build upon the idea of Henri de Saint-Simon(9) (1760-1825) who described a technocratic utopia based on technical-scientific principles. Comte founded sociology, and his positivist(10) philosophy came to have a great impact on modern science and philosophy.

But it was with the manifestation of the fruits of the Industrial Revolution in the late eighteenth century onwards that philosophers began to ask critical questions about technology. The perception that technology could have a negative impact on human life was first expressed in the Romantic movement(11). The Romantic movement partially constituted a reaction against the Industrial Revolution, which created aesthetically(12) unpleasant and dirty, polluted industrial cities populated by masses of poor people. For the Romantics, the Industrial Revolution, made possible through the emergence of new technology, destroyed both nature and people alike. An early, prescient(13) expression of this view had been put forward in 1750, unlike many of his contemporaries, by Jean-Jacques Rousseau(14) (1712-78), in his *Discourse sur les Science et les Arts*. In it he criticized the core idea of the Enlightenment(15), that science and technology automatically lead to the progress of society. He claimed that, on the contrary, the emergence of modern science and technology had been directly detrimental(16) to society and its morality.

令和７年度入学者選抜試験 問題用紙（英語その2）　— 後期 —

The Late Romantic critique of technology and science and how it destroys people's lives is vast, but a good later representative of this school of thought is the German historian Oswald Spengler (1880-1936), who in *The Decline of the West* (1918) described how Western civilization was experiencing a crisis similar to that which people experience on the threshold of old age. In essence, his was a warning of the consequences of humanity's blind worship of technology: it's unnatural, but also unconditional, and this means technology rules over people as a lord rules over his slaves. Like the earlier Romantics, Spengler was reacting against a machine-dominated society and big industry, instead encouraging a simpler lifestyle, with a closer, more symbiotic relationship with nature. He argued that society should be governed by reason in the form of one 'Enlightened despot(17)' of high moral caliber(18) and intellectual standing ('*un despotisme juste et eclaire*').

出典: Helena Moradi "Technology & Transformation"より一部改変

［注釈］

(1) プラトン、古代ギリシャの哲学者 (2) エピステーメー、如何なる時であっても知的観点から確実な知識を決定する思考体系 (3) アリストテレス、古代ギリシャの哲学者 (4) ルネ・デカルト、近世欧州の哲学者 (5) 不可避な (6) ゲオルク・ヴィルヘルム・フリードリヒ・ヘーゲル、ドイツの哲学者 (7) オーギュスト・コント、フランスの哲学者 (8) 形而上学 (9) アンリ・ド・サン＝シモン、フランスの哲学者 (10) 実証主義の (11) ロマン主義運動 (12) 審美的に (13) 予知的、予測的 (14) ジャン＝ジャック・ルソー、フランス/ジュネーヴの哲学者 (15) 啓蒙主義 (16) 有害な (17) 専制君主 (18) 器量、資質

問1. 古代ギリシャの哲学における「技術」と現代における「技術」の捉え方の違いを、日本語で説明してください。

問2. ベーコンとルソーは、それぞれの時代の技術や科学にどのような先見性を持っていたか、日本語で説明してください。

問3. 後期ロマン主義の主張を日本語で説明してください。

問4. コントの思想はガリレオの思想とどのように関連しているか、ヘーゲルの思想と対比させて日本語で説明してください。

問題 2 次の文章を読み、筆者の主張を踏まえて以下の問に答えてください。

The lack of distinctions between singular and plural or between definite and indefinite contributes to the ambiguity, at least to the Western reader who is accustomed to such distinctions. For a Japanese poet precision in language would limit the range of suggestion, as we can easily see from a famous haiku by Bashō (1644-1694):

kareeda ni	On the withered bough
karasu no tomarikeri	A crow has alighted:
aki no kure	Nightfall in autumn.

This English translation represents a possible interpretation of the Japanese words, but the arbitrary(1) nature of its choices of singular and plural is apparent from an eighteenth-century painting illustrating this *haiku* that depicts no less than eight crows alighted on a number of withered(2) branches. This equally possible interpretation of the poem presents a landscape less lonely than that of a single crow on a single withered branch, an interpretation of the poem found in other illustrative paintings, but may convey an even more brooding(3) intensity. Again, the last line of the *haiku*, *aki no kure*, can also be interpreted as meaning“the nightfall of autumn”–that is, the end of autumn. If we were to insist on determining which meaning the poet intended, whether the night-fall of a particular autumn day or the end of the autumnal season, the answer might well be that both were intended. If Bashō’s phrase were interpreted as meaning nightfall, regardless of whether it were early or late in autumn, it might suggest that the crow (or crows) were alighting(4) on a withered branch in a tree otherwise filled with bright leaves, producing a disharmonious(5) impression; but if the scene intended had been an unspecified time of day toward the end of autumn, it might mean that the crow was alighting in the full glare(6) of noon, an equally inappropriate possibility. Many meanings and implications may be extracted from the seventeen syllables of this *haiku*, thanks to the ambiguity of the language. However, Bashō’s ultimate meaning, what he intended the two elements of the *haiku* to say about each other, and how far beyond the words themselves the suggestions reach, may still elude us.

The *haiku* on the alighting crow exemplifies(7) a related aspect of Japanese aesthetics(8), the preference for monochromes to bright colors. It is true that magnificent examples of Japanese art-the celebrated *Tale of Genji* scroll among them-are brilliantly colored, but I believe that most Japanese critics would agree that the prevailing preference in Japanese aesthetics has been for the monochrome. The black crow alighting on a withered branch at a time of day and season when all color has vanished suggests the lonely beauty admired by countless Japanese poets, or the severity(9) of Japanese gardens consisting of stones and sand, or the unpainted interiors and exteriors of a Japanese house. The use of color can be brilliant, but it inevitably limits the suggestive range: when a flower is painted red, it can be no other color, but the black outline of a flower on white paper will let us imagine whatever color we choose.

These words may suggest the aesthetics of Zen Buddhism. Indeed, much of what is considered most typical in Japanese aesthetics stems from Zen. Or, it might be more accurate to say, it coincides(10) with Zen. The simplicity of a Shintō shrine building, the bare lines of its architecture and grounds, was an expression of an indigenous(11) preference which coincided with Zen ideals, and made the Japanese receptive(12) to the more sophisticated aesthetics of the continental religion. The Japanese were equally receptive to the aesthetics of the Chinese artists and poets of the Sung dynasty(13) who also favored monochromes. <u>But the principle of suggestion as an aesthetic technique need not have been learned from abroad.</u>

Suggestion as an artistic technique is given one of its most perfect forms of expression in the Nō theatre. The undecorated stage, the absence of props(14) other than bare outlines, the disregard for all considerations of time and space in the drama, the use of a language that is usually obscure and of abstract gestures that scarcely relate to the words, all make it evident that this theatre, unlike representational examples elsewhere (or Kabuki in Japan) was meant to be the outward, beautiful form suggestive of remoter truths or experiences, the nature of which will differ from person to person. The large role played by suggestion, as contrasted with the explicit(15) descriptions of people and situations we more normally encounter in the theatre, gives the Nō an absolute character. It baffles(16) or bores many Japanese, but it moves others in ways that more conventional, dated varieties of drama cannot, and the same holds true of Western spectators. The groans, the harsh music that precedes the entrance of the actors, may irritate a contemporary spectator, but they may also make him sense in a way impossible with words alone the distance separating the world of the dead from the world of the living, the terrible attachment to this world that causes ghosts to return again to suffer the past, or the pain of being born.

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Nō can profoundly move even Western spectators totally unfamiliar with Japanese culture, but it can equally repel(17) others who are committed to a representational variety of theatre. Performances staged in Europe and America have been criticized as having insignificant plots and inadequate characterization. After a performance in New York a member of the Actors' Studio complained that the character Tsunemasa did nothing to convince the audience he was indeed a great musician. Such objections, which would be scornfully rejected by admirers of Nō, cannot be attributed merely to the hostility of people ignorant of tradition. Suggestion as an aesthetic method is always open to the charge of deception–of being no more than the Emperor's new clothes.

出典: Donald Keene "Japanese Aesthetics" より一部改変

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［注釈］

(1) 任意の、気まぐれな (2) しぼんだ、枯れた (3) 陰気な、気が滅入る (4) 舞い降りる (5) 不調和な (6) ギラギラ輝く (7) ～の良い例となる (8) 美学、美意識 (9) 厳格さ (10) 同時に起こる、一致する (11) 原産の、生来の (12) 取り入れようとする、受容可能な (13) 宋王朝 (14) 小道具 (15) 曖昧さのない、明確な (16) 困惑させる、まごつかせる (17) 寄せ付けない、不快にさせる

問 1. 芭蕉の俳句の曖昧さと、その効果について、30-50 words の英語で説明してください。

問 2. 芭蕉には以下の有名な俳句があります。英訳してください。英訳の文字数は問いません。また、そのように英訳した理由を上記の文章を踏まえて、30-50 words の英語で説明してください。

furuikeya　/　kawazu tobikomu　/　mizu no oto

問 3. 日本人は単色 "monochrome" を好むと説明されています。賛成意見と反対意見の両方を考え、それぞれその理由を具体例とともに、30-50 words の英語で説明してください。なお具体例を記載する場合は、"*Kabuki*" のようにローマ字表記で構いません。

問 4. 下線部の理由を 30-50 words の英語で説明してください。

問 5. 演劇と能楽の違いを 30-50 words の英語で説明してください。

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問題 3　以下の英文の指示に従い問に答えてください。

The following article is from a medical reference resource and discusses the diagnosis of conversion disorder (**f**unctional **n**eurological **s**ymptom **d**isorder, or FNSD). FNSD is a disorder where patients experience problems of movement and sensation such as paralysis, numbness, blindness, deafness, or seizures, *without* having any clearly documentable physical disease process of the brain, nerves, or muscles.

Answer whether the following "**Statements**" are true (T) or false (F), or whether there is no corresponding information available (NCIA). Base your answer on information and opinions stated in the text. Circle one. If your answer is T or F, also write the line number from which you draw that conclusion. You will be penalized for wrong choices.

If your justification spans multiple lines of the main text, write one line number which includes your justification. (There *may* be instances where multiple answers are accepted to be correct, as illustrated in the following **"Example Statement and Answer."**) A partial glossary of key terms is given at the end of the text, which describes specific terms *as they are used within the main text*.)

Example Statement and Answer

0. At the beginning of the assessment, you should make a complete list of the patient's symptoms. This prevents the patient from coming up with more and more symptoms as the assessment progresses.

0. T (line number: **20**) ・ F (line number:) ・ NCIA

↑ **"21"** *will also be accepted as correct*

Reason for the above answer: *the above statement 0. can be determined to be true, based on lines 20-21 of the main text.*

Statements

1. As a general principle, patients who are found to have true epilepsy cannot be diagnosed with FNSD.
2. As a general principle, during assessment for suspected FNSD, you should drop indirect and fragmentary hints to the patient about the diagnosis, so that they are prepared to hear the truth at the end.
3. As a general principle, if a patient is diagnosed with FNSD, this fact should not be disclosed to them until treatment is completed.
4. Within the disease history, at onset, "functional symptoms" usually start with a hysterical outbreak or loud screaming.
5. The level of disability experienced by patients with FNSD is usually exaggerated, and more severe than would be expected from common neurological diseases.
6. Over 50% of patients with FNSD are aware that their symptoms do not stem from a clear physical disease and are exclusively psychological in nature.
7. Patients most commonly develop FNSD in early adulthood.
8. Patients with FNSD usually attribute their symptoms to psychologic factors such as excessive stress.
9. Boys develop FNSD more often than girls.
10. The severity of functional symptoms is a direct causal result of psychosocial functioning, but those functional symptoms do not in turn affect the severity of psychosocial dysfunction in any manner.
11. It is common that family members of patients with FNSD have various illnesses.
12. Asking patients to draw a timeline graph of the course of their illness can be effective.
13. When speaking to a patient who may have FNSD, an effective strategy is to start the interview by asking whether the patient has had adverse life experiences, such as childhood neglect or physical and sexual abuse.
14. *"La belle indeference"* is specific to FNSD.
15. FNSD is a diagnosis of exclusion, based on careful documentation of negative findings (the lack of specific findings).
16. FNSD may have a biological basis in neural network states not yet identified, and may not be "fake."
17. The presence of recognizable neurologic disease demonstrates that the patient does not have FNSD.
18. Since FNSD is clearly psychiatric in nature, medical examination for non-psychiatric diseases is not necessary.
19. Patients suspected of FNSD should be told beforehand that their radiological imaging findings will likely be normal.
20. Radiological spine imaging of an 80-year-old patient without symptoms is expected to reveal disk prolapse in most cases.

General principles — Functional neurological symptom disorder (conversion disorder) can present with various symptoms, which may be episodic or sustained, and acute or chronic.

Assessment of patients presenting with possible functional neurological symptom disorder includes a medical history, physical examination, and indicated laboratory tests, as well as a psychiatric history and mental status examination. Patients are encouraged to recount all previous medical encounters and psychiatric diagnoses. Obtaining past medical records can help provide information about symptoms or problems that patients may have forgotten or not recognized as a functional disorder.

It is essential to look for neurologic and other general medical conditions, particularly early-stage diseases. The clinical evaluation should emphasize diseases that explain the patient's symptoms better than functional neurological symptom disorder, as well as diseases that are comorbid; among patients with nonepileptic seizures, approximately 10 to 20 percent also have epilepsy, and patients with multiple sclerosis may also have functional limb weakness.

Comorbid psychiatric disorders are often present, but may be difficult to discern because patients focus upon physical symptoms rather than symptoms of depressive and anxiety disorders.

Avoid indirect and fragmentary discussions of the diagnosis during the assessment. Instead, clinicians should understand that successfully presenting the diagnosis of functional neurological symptom disorder to patients is a fundamental aspect of treatment.

Patients diagnosed with functional symptoms should be reevaluated periodically because in rare cases a general medical etiology may take years to become evident.

History — Clinicians taking the history of patients with a possible diagnosis of functional neurological symptom disorder should ask about the following:

- **All current somatic symptoms** – Making a complete list of the symptoms at the beginning of the assessment can prevent new symptoms from appearing later. It can also be therapeutic as patients may feel more understood and unburdened. We routinely ask about fatigue, pain, dizziness, sleep disturbance, and impaired memory and concentration if the patient does not volunteer these. After the list is complete, return to each symptom as necessary.

Multiple current neurologic symptoms are often found in functional neurological symptom disorder. In a prospective study of 54 patients with functional neurological symptom disorder, mixed symptoms occurred in 35 percent, and a randomized trial of 127 patients with the disorder found that the mean number of functional symptoms was 2.5.

Patients with functional neurological symptom disorder often report a large number of current or prior physical symptoms, dissociative symptoms, or functional disorders (e.g., irritable bowel syndrome, fibromyalgia, or chronic fatigue syndrome), in addition to functional symptoms.

- **Circumstances at onset** – Clinical features that are commonly observed at onset of functional symptoms include panic attacks, migraine headache, or pain, as well as physical injury. A systematic review of 132 observational studies of functional neurological symptom disorder (869 patients) found that immediately prior to onset, physical injury occurred in 37 percent. Although subsequent studies are consistent with this finding, physical injury is not specific to functional neurological symptom disorder. In addition, both functional (psychogenic) nonepileptic seizures and functional motor symptoms may occur after general anesthesia.

Onset of functional symptoms is often sudden. As an example, a prospective study of 107 patients with functional weakness found that sudden onset (≤6 hours to maximal onset) while awake occurred in 46 percent, or upon waking from sleep or general anesthesia in 15 percent.

- **Dissociation** – Dissociation in the form of depersonalization or derealization may be present in patients with functional neurological symptom disorder, particularly at onset of the disorder or in association with a nonepileptic seizure. Patients may describe dissociative symptoms as feeling "outside of myself," "spaced out," "far away," or "unreal."
- **Disability** – Patients with functional neurological symptom disorder experience disability and distress that is comparable with patients with recognizable neurologic disease. Asking "What is a typical day like?" or "Do you spend much time in bed or out of the house?" may be more informative than asking patients what they cannot do.
- **Awareness of symptoms** – Asking patients what they think may be causing their neurologic symptoms and what should be done to treat them enables clinicians to tailor their explanation of the diagnosis and rationale for treatment.

Patients are frequently dissatisfied with exclusively psychologic explanations for their neurologic symptoms, and

may be less likely to attribute their symptoms to psychologic factors. In one prospective study (n = 153), the belief that stress was a possible cause of the illness occurred in fewer patients with functional weakness than patients with weakness due to recognizable neurologic disease (24 versus 56 percent).

●**Psychosocial functioning** – The relationship between functional symptoms and psychosocial functioning is bidirectional (each can affect the other).

●**Family history** – Illnesses in parents, siblings, and children are common in patients with functional neurological symptom disorder. As an example, one prospective study (n = 60) found that general medical disorders in first-degree relatives were more common among patients with functional neurological symptom disorder than patients with recognizable neurologic disease (80 versus 37 percent of patients). Psychiatric disorders were also more common in relatives of functional neurological symptom disorder patients. In addition, some studies have found that patients with functional neurological symptom disorder have a family history of functional neurological symptom disorder. However, it is not established that patients with functional neurological symptom disorder mimic the symptoms of other individuals.

●**Course of illness** – Asking “When did you last feel well” is a useful way of determining when onset of functional symptoms occurred, particularly for patients who have been ill for several years. In addition, a large amount of information can be condensed by drawing a graph with time on the x axis, severity of symptoms on the y axis, and adding life events or treatments. The intensity of functional symptoms may fluctuate.

●**Previous functional disorders and functional symptoms** – Previous functional disorders such as irritable bowel syndrome or fibromyalgia, or prior functional symptoms, can be helpful as evidence of a patient’s vulnerability to functional neurological symptom disorder.

●**Prior clinical experiences** – Patients may have experienced iatrogenic harm from a misdiagnosis of recognized neurologic disease, unnecessary tests or medication, and from feelings of powerlessness when a doctor appears not to know what is wrong with them. Reports of feeling disbelieved and ensuing self-doubt about the veracity of one’s own symptoms is common.

●**Recent psychological stressors** – Although adverse life events are common in patients with functional symptoms, many patients do not have obvious life events and stressors. In addition, psychological factors are not specific to functional neurological symptom disorder and can be diagnostically misleading if given too much weight.

●**Symptoms of comorbid psychiatric disorders** – We typically leave questions about feelings of depression and anxiety until the end of the assessment (unless the patient volunteers these symptoms). Patients may understandably become defensive if they think that their symptoms will be ascribed to a “mental disorder.” For many patients, attributing physical symptoms to a mental disorder is the same as suggesting that the symptoms are “fake.” It may thus be helpful to avoid using terms such as depression or anxiety and frame the questions in terms of the presenting symptoms. As an example, we may ask “Does your weakness ever make you feel down or frustrated?” instead of “Have you been feeling depressed?” Anxiety and dysphoria are often but not always present in patients with functional neurological symptom disorder.

●**Physical and sexual abuse** – Questions about abuse or adverse experiences, like those for comorbid psychiatric disorders, are often best left to the end of the assessment or a follow-up visit. Patients may be more forthcoming after trust has been established during the preceding phases of the assessment. It is important to provide patients enough time to discuss the issue if they volunteer information about abuse; clinicians pressed for time will be better served by asking about abuse during a subsequent interview or leaving this to a different clinician.

A prior history of childhood abuse or neglect is more common in patients with functional neurological symptom disorder than patients with neurologic disease and healthy controls. However, it is not clear that a history of sexual abuse is more common in functional neurological symptom disorder than patients with other psychiatric disorders, and most patients with functional neurological symptom disorder have not experienced abuse or neglect.

Other clinical features previously identified as specific to functional neurological symptom disorder include *“la belle indifference”* and a predominance of left-sided symptoms; however, the evidence indicates that these two features are not specific to patients with functional neurological symptom disorder.

La belle indifference, which refers to an incongruous lack of concern (indifference) about significant symptoms, has no validity in discriminating functional neurological symptom disorder from recognizable neurologic disease. In a systematic review of 11 prospective or retrospective studies, the median frequency of la belle indifference was comparable for patients with

functional neurological symptom disorder (n = 356) and patients with defined neurologic disease (n = 157; 21 versus 29 percent). In our experience, la belle indifference often indicates that patients are trying to appear brave or cheerful in the presence of actual distress (to avoid receiving a psychiatric diagnosis such as depression), or may less often suggest factitious disorder.

Unilateral functional symptoms do not appear to be more common on one side of the body than the other. Although a meta-analysis of 90 observational studies (1139 patients with functional symptoms) found that left-sided symptoms occurred in more patients than right-sided symptoms (58 versus 42 percent), this finding appeared to be due to reporting bias. A separate analysis was conducted in the 78 studies (553 patients) in which laterality was reported incidentally in the study text and did not appear in the title; a left-sided preponderance of symptoms was found in only 53 percent of patients.

Examination — For patients who present with symptoms that may represent functional neurological symptom disorder, the principles of assessment are to look for evidence of:

- Inconsistency at different points in the examination (e.g., a patient with no ankle plantar flexion while supine on the examination table is able to stand on tip toes). In addition, observing patients before and after the formal examination can be revealing. As an example, compare the patient's gait entering and leaving the examination room, what occurs when patients take their clothes off and put them on, or what occurs when they retrieve something from their bag.
- Incongruity between the symptoms and recognized disease, (i.e., the symptoms do not conform to known anatomical pathways and physiologic mechanisms). As an example, a tubular visual field defect is inconsistent with the laws of optics and eye physiology.

Thus, the diagnosis of functional neurological symptom disorder rests upon positive clinical findings, which are described below.

However, patients with recognizable neurologic disease may also display these positive findings, indicating the presence of functional disorder comorbidity (also called "functional overlay"). In addition, inconsistent signs may be produced consciously (as in factitious disorder or malingering).

Additional information about the medical evaluation for functional neurological symptom disorder is discussed separately in the context of somatic symptom disorder.

Laboratory and radiologic studies — Laboratory, radiologic, and neurophysiologic tests are generally required to seek neurologic/general medical disorders that either explain the presenting symptoms or are comorbid. However, the diagnosis of functional neurological symptom disorder is not one of exclusion and rests upon positive clinical findings, rather than negative tests. Although negative test results are consistent with the diagnosis in most patients with functional neurological symptom disorder, many patients with neurologic disorders have normal test results, and a diagnosis of functional neurological symptom disorder can still be made when an additional neurologic disease is present (as long as that disease is not a better explanation for the examination findings).

Investigations should be performed as quickly as possible; protracted testing may encourage diagnostic uncertainty in patients, who then focus upon finding a disease rather than rehabilitation. We are explicit about why we are ordering the tests, and predict the results will be normal when this is reasonable.

We warn patients that testing may uncover abnormalities that are unrelated to the presenting symptoms (but which derail treating the symptoms). As an example, a meta-analysis of 16 studies with more than 19,000 individuals found that incidental findings occur in approximately 3 percent of brain magnetic resonance images. In addition, spinal imaging of asymptomatic individuals shows disc prolapses at a frequency percentage roughly equal to the patients' "age plus 10". Tests can also yield false negatives.

(Extracted and modified from UpToDate® Topic 85765 Version 20.0, by J. Stone and M. Sharpe)

Glossary of key terms (As they are used within the text)

adverse: opposed to one's interests, unfavorable or harmful
asymptomatic: showing or producing no symptoms of a medical condition
clinical: of or relating to the care of sick patients, usually in medical settings such as a hospital
clinician: a doctor or other medical professional conducting the care of sick patients
cognitive: of, relating to, being, or involving conscious intellectual activity (such as thinking, reasoning, or remembering)
comorbid: existing simultaneously with and usually independently of another medical condition
complaint: a problematic medical condition which the patient brings to the medical team's attention
derail: to obstruct the progress of something
defensive: devoted to resisting or preventing aggression or attack, both physical and verbal
depersonalization: a mental state characterized by loss of identity and feelings of unreality about one's behavior
derealization: a feeling of altered reality in which one's surroundings appear unreal or unfamiliar
depression: a mood disorder that is marked by varying degrees of sadness, despair, and loneliness
diagnosis: the art or act of identifying a disease from its signs and symptoms
discern: to come to know or recognize mentally
dissociative: the separation of whole segments of the personality or of discrete mental processes from the mainstream of consciousness or of behavior
disc prolapse: abnormal bulging out of the soft tissue cushion between the bones of the spine
dizziness: having a whirling sensation in the head with a tendency to fall
epilepsy: various disorders marked by electrical discharges in the brain and typically manifested by altered consciousness or involuntary movements
evaluation: determination of the value, nature, character, or quality of something, for example, a disease
factitious: produced by a human intentionally rather than by natural forces or diseases, especially regarding fake symptoms
fatigue: weariness or exhaustion from labor, exertion, or stress
fibromyalgia: a chronic disorder characterized by widespread pain, tenderness, and stiffness of muscles, typically accompanied by fatigue, headache, and sleep disturbances
finding: the results of a clinical investigation or examination
functional: (of a mental illness) having no clear cause in body states as observable by examination or testing
forthcoming: characterized by openness, candidness, and forthrightness
incidental finding: a finding occurring merely by chance, or without relation to the reason a test was conducted
incongruous: lacking congruity, such as being inconsistent with itself
inconsistent: lacking consistency: such as, not compatible with another fact or claim
indifferent: marked by a lack of interest, enthusiasm, or concern for something
laterality: the state of lying at or extending toward one direction, toward the right or left side
meta-analysis: a quantitative statistical analysis of several separate but similar experiments or studies in order to test the pooled data for statistical significance
motor: relating to muscular movements, or to the nerves and brain regions causing such movements (see **sensory**)
neglect: an act or instance of neglecting something, such as the care of a child
neurology: a branch of medicine concerned especially with function and diseases of the nerves and brain (see psychiatry)
non-epileptic seizure: seizures that are not caused by epilepsy and may result from physical causes such as low blood sugar or psychological causes as discussed in the text
observational study: a study which documents and observes variables without conducting an active intervention
onset: beginning
paralysis: loss of the ability to move
plantar flexion: movement of the foot where the foot bends down toward the sole, opening up the ankle
predominant: being most frequent or common
physical symptom: a symptom which is manifested in the body or in bodily function, as documented by examination or testing
psychosocial: involving both psychological and social aspects
psychiatry: a branch of medicine that deals with mental, emotional, or behavioral disorders (see neurology)
radiologic: of or relating to radiology, a branch of medicine concerned with the use of radiant energy (such as X-rays) or radioactive material in the diagnosis and treatment of disease
rationale: underlying reasoning or thought process
sensory: relating to sensation or the senses, or to the nerves and brain regions involved in processing them (see **motor**)
somatic symptom: a symptom outwardly affecting the body, instead of just the mind
symptom: subjective evidence of disease or physical disturbance
tubular visual field defect: a visual field limitation where vision remains intact only in a tunnel-like circular form
unilateral: of, relating to, or affecting one side of a subject

問題 4 次の文章を読み、筆者の主張を踏まえて以下の問に答えてください。

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著作権の関係により掲載できません

出典：Chip Heath and Dan Heath“Switch”より一部改変

[注釈]

(1) 小走りでいく　(2) 支離滅裂な、統合失調症　(3) 抱きしめた (4) わんぱくな (5) 単刀直入の (6) 良識のある　(7) 映画 Star Trek の登場人物 (8) 奇妙な (9) アメリカのスナック菓子 (10) アメリカのクッキー (11) 食品庫　(12) 強く欲しがること　(13) プラトン；古代ギリシャの哲学者　(14) 馬車の御者 (15) 操る、手綱を握る　(16) 手に負えない (17) 突き棒　(18) フロイト；オーストリアの心理学者、精神科医 (19) 良心的な　(20) 呼ぶ　(21) 行為者 (22) おぼつかない　(23) 前の恋人　(24) ぐずぐずと先延ばしにする　(25) 移り気な　(26) 満足させること　(27) 不自由な　(28) 得意分野　(29) 背骨　(30) 熟慮する (31) 粗野な　(32) 苦悩する　(33) 欠陥　(34) 麻痺する

令和 7 年度入学者選抜試験 問題用紙（英語その12）　— 後期 —

問 1. 本文中で“Rider” および “Elephant”と同義あるいはその特徴を表す語句を、それぞれできるだけ多く書き出してください。（各語句の間には“/”を入れてください。誤答は減点の対象となります。）

問 2. 以下の英文を読んで問(a)~(c)に答えてください。

著作権の関係により掲載できません。

出典：Chip Heath and Dan Heath “Switch” より一部改変

[注釈]

（35）引っ張る　（36）用意した　（37）かじる　（38）用意された、次の

（a） 文中の四角の中に入る適当な英語を記載してください。

（b） 文中の下線部は具体的にどのような実験結果が出たのか、日本語で簡潔に説明してください。

（c） 文中の下線部のような実験結果が出た理由を、上記の本文中の“Rider”と“Elephant”との関係性から類推して、日本語で説明してください。

令和７年度入学者選抜試験 答案用紙（英語その13）　— 後期 —

問題１

問 1.

問 2.

問 3.

問 4.

受　験　番　号

小　計

令和７年度入学者選抜試験 答案用紙（英語その14）　— 後期 —

問題 2

問 1.

問 2.

俳句の英訳）

理由）

問 3.

賛成意見）

反対意見）

問 4.

問 5.

受　験　番　号

小　計

令和７年度入学者選抜試験 答案用紙（英語その15）　— 後期 —

問題 3

1. T (line number:) ・ F (line number:) ・ NCIA
2. T (line number:) ・ F (line number:) ・ NCIA
3. T (line number:) ・ F (line number:) ・ NCIA
4. T (line number:) ・ F (line number:) ・ NCIA
5. T (line number:) ・ F (line number:) ・ NCIA
6. T (line number:) ・ F (line number:) ・ NCIA
7. T (line number:) ・ F (line number:) ・ NCIA
8. T (line number:) ・ F (line number:) ・ NCIA
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10. T (line number:) ・ F (line number:) ・ NCIA
11. T (line number:) ・ F (line number:) ・ NCIA
12. T (line number:) ・ F (line number:) ・ NCIA
13. T (line number:) ・ F (line number:) ・ NCIA
14. T (line number:) ・ F (line number:) ・ NCIA
15. T (line number:) ・ F (line number:) ・ NCIA
16. T (line number:) ・ F (line number:) ・ NCIA
17. T (line number:) ・ F (line number:) ・ NCIA
18. T (line number:) ・ F (line number:) ・ NCIA
19. T (line number:) ・ F (line number:) ・ NCIA
20. T (line number:) ・ F (line number:) ・ NCIA

受　験　番　号

小　計

令和 7 年度入学者選抜試験 答案用紙（英語その16）　— 後期 —

問題 4

問 1.

“Rider”と同義あるいはその特徴を表す語句

“Elephant”と同義あるいはその特徴を表す語句

問 2.

（a） That’s _____ at work.

（b）

（c）

受　験　番　号

小　計