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Research on the Current Situation of Mental Health in Rural Community and Urban Community

Daozheng QU^{1*}, Gongyi ZHANG¹, Wei HUANG¹, Meiling XU²

1. Social Development Research Center, Jilin University, Changchun 130021, China; 2. China Electronics Technology Group Corporation, Nanjing 210007, China

Abstract There are few studies on the treatment orientation of psychological counseling and psychotherapy practitioners in China. Additionally, integrative therapy as the first choice is much commoner in less developed areas and among unsupervised practitioners, which reflects the risk of technical confusion relating to the use of integrative therapy in China. The counseling and psychotherapy practitioners are treated as "variables", and researchers are concerned because these "variables" can have a significant impact on the course of treatment and outcomes. Therefore, we analyze the effects of socioeconomic development level on practitioners' treatment orientation. Based on the results, in addition to areas of employment, urban stratification and practitioners' system factors, gender, age, education, professional background, work hours, and other factors affect psychological counseling and psychological treatment practitioners.

Key words Urban stratification, Psychological counselor, Social development level, Treatment orientation

1 Introduction

With social changes, modifications in each person's inner world are unprecedentedly sharp. Additionally, everyone experiences the active or passive mental and behavioral adjustments to adapt to rapid changes. In the process, mental health becomes important^[1]. Therefore, psychological counseling and treatment have begun to enter into people's lives. In 2003, the Chinese Ministry of Labor and Social Security organized the first psychological counselor vocational qualification examination^[2]. Since then, psychological counseling and treatment in China have gradually become promising careers. For example^[3], in 2002, 10 000 to 20 000 people were employed as psychological counselors and psychotherapists in China. From 2003 to 2007, nearly 100 000 people took the Psychologist Professional Qualification Examination^[4–5]. The number of mental health professionals in general hospitals and psychiatric hospitals in China was approximately 12 000 in 2001^[6]. The growth rate was approximately 12% compared to 2001. Currently, the majority of psychological counseling and treatment practitioners in China are female^[6, 10] and are generally between 30 and 45 years of age, with an average of approximately five years of experience^[10]. Nearly 40% of them have been practicing for fewer than three years^[12]. Among the practitioners, an undergraduate degree is the main educational attainment. Approximately one third of them have a psychological background. Approximately one fourth of them have a medical background. In terms of pedagogical and other backgrounds, the ratio of psychological background to pedagogical background is approximately 1:5. However, the proportion of medical back-

grounds has shown a declining trend^[10, 13]. Many practitioners have been trained while practicing^[14], having an average of approximately 140 h of continuing education^[15]. In addition, approximately 40% of them are full-time employees^[6], and less than 30% of them have a professional certificate^[16]. In terms of the proportion of supervision and guidance^[10, 17–18], less than 60% of them receive supervisory guidance^[17].

Given that the number of psychological institutions and employees as well as the institutional setting is correlated with the disposable income per capita of local residents, the number of psychological institutions in East China and Central China is greater than that in Northwest China. The number of institutions in Beijing, Shanghai and Guangzhou, is also significantly larger than the number of psychological institutions in Yinchuan, Lhasa and other cities^[11]. At the same time, China's psychological counseling and psychotherapy practitioners are mainly distributed in schools, hospitals and other sectors of society in which people seek treatment groups. Practitioners' backgrounds are not the same, so they need to study the different socioeconomic levels and geographical locations as well as the diverse clinical characteristics of the therapists in different occupational systems. The current study of the demographic characteristics of psychological counseling and psychotherapy practitioners has an imperfection, namely the level of socioeconomic development and the practitioners' system are analyzed at the same time.

Therefore, we first need to focus on the environmental and demographic factors relating to practitioners' choice of treatment orientation. Then we conduct a study on the treatment orientation of psychological counseling and psychological treatment practitioners in China, and analyze the influence of environmental^[7–9] and demographic factors to fill the gaps in previous studies and to provide a reference for the future research.

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* Corresponding author. E-mail: 18618211019@qq.com

2 Basic principles and methods

The objectives of the study are to design a cross-sectional survey of practitioners in China who are currently engaged in psychological counseling and psychotherapy and to employ convenience sampling and multi-level stratification of the district and subsystem. Ac-

cording to China's administrative divisions, the Mainland is divided into six administrative regions: Northeast (Zone 1), North (Zone 2), Central South (Zone 3), East (Zone 4), Northwest (Zone 5), and Southwest (Zone 6) (Table 1).

Table 1 The top ten preferred therapies by different zones

	Zone 1[a]	Zone 2[b]	Zone 3[c]	Zone 4[d]	Zone 5[e]	Zone 6[f]
Name of therapy	(<i>n</i> = 1 990)	(<i>n</i> = 1 960)	(<i>n</i> = 1 920)	(<i>n</i> = 1 860)	(<i>n</i> = 1 960)	(<i>n</i> = 2 200)
Cognitive therapy	1 120 (56.3)	660 (33.7)	700 (36.5)	630 (33.9)	870 (44.4)	1 000 (45.5)
Psychoanalysis	280 (14.1)	340 (17.3)	350 (18.2)	450 (24.2) ef	210 (10.7)	240 (10.9)
CBT	90 (4.5)	250 (12.8)	190 (9.9)	270 (14.5) a	260 (13.3) a	170 (7.7)
Behavioral therapy	110 (5.5)	130 (6.6)	80 (4.2)	80 (4.3)	180 (9.2)	180 (8.2)
Client—Centered therapy	40 (2.0)	100 (5.1)	80 (4.2)	130 (7.0)	40 (2.0)	90 (4.1)
Integrative therapy	40 (2.0)	20 (1.0)	120 (6.3)	70 (3.8)	180 (9.2) ef	20 (0.9)
General psychotherapy	70 (3.5)	60 (3.1)	120 (6.3) e	30 (1.6)	10 (0.5)	90 (4.1)
Sand table therapy	50 (2.5)	40 (2.0)	70 (3.6)	20 (1.1)	0 (0.0)	110 (5.0)
Family therapy	10 (0.5)	60 (3.1)	10 (0.5)	20 (1.1)	40 (2.0)	80 (3.6)
Hypnotherapy	0 (0.0)	80 (4.1)	40 (2.1)	40 (2.2)	30 (1.5)	0 (0.0)
Other therapies	180 (9.0)	220 (11.2)	160 (8.3)	120 (6.5)	140 (7.1)	220 (10.0)

"Stratification" means that based on the level of development of the psychological counseling and psychological treatment industry, the cities included in the administrative regions are divided into three levels, developed, medium-developed and underdeveloped, which are labeled A-layer, B-layer and C-layer. Since the psychological counseling and treatment industry development level and the city's socioeconomic and cultural level are proportional, A-layer cities are usually the provincial capital cities or metropolises, B-layer cities are medium-size cities, and C-layer cities are small cities or towns. "Subsystem" refers to China's psychological counseling and psychotherapy practitioners, who are divided into three systems. The education system includes primary, secondary and primary schools, vocational and technical schools, and various training institutions affiliated with schools. Medical systems include psychiatric hospitals, general psychiatric and clinical psychiatrists, and hotline counseling services provided by hospitals. Other social systems include psychological institutions of the private sector, the prison system of psychological workers, businesses and government non-educational institutions, the non-medical sector, psychological practitioners, and institutions that are affiliated with psychological training institutions and hotline services.

Based on previous experience in similar studies and the conditions of this study, a sample size of at least 12 000 people with an equal ratio assigned to the six administrative zones (with each administrative zone having approximately 2 000 people) is required. As the level of development of the industry in different parts of the sample has produced different degrees of difficulty, the developed city (A layer) sample size accounts for approximately 60% of the sample (1 200 people per area). The medium-developed city (B layer) sample accounts for approximately 30% (600 people per area), whereas the underdeveloped city (C layer) accounts for approximately 10% (200 people per area). Three layer cities are sampled, and each layer accounts for approximately one-third of the sample:

$$N = t^2 p(1 - p) / \Delta p^2.$$

Among the factors that are related to the treatment orientation, the partition, stratification, subsystem and ten demographic components mentioned above are selected, and the continuous data conversion method is employed as described above^[17]. For the demographic component, the chi-square test is used to compare the differences. Based on the number of comparisons, the significance level ($\alpha = 0.05$) is adjusted using the Bonferroni method ($\alpha^2 = 0.05 \div 6 = 0.083$). The number of comparisons across the six groups is 15 ($\alpha^3 = 0.05 \div 15 = 0.0033$). For the treatment-oriented part, the chi-square test is first used for each of the relevant factors. Additionally, the choice of treatment is associated with the univariate analysis, test level and demographic part. According to the results of the univariate analyses, cognitive therapy and psychoanalysis are the two most significant treatments. The first choice of cognitive therapy and psychoanalysis are used as the references. Logistic regression of multiple disorder response variables is used to analyze the selected model. The correlation between the factors and the preferred treatment, 95% CI are calculated. $P < 0.05$ is considered to be statistically significant (Table 2).

3 Results

The following results relate to age, gender, educational background, professional background, working time, supervision and guidance of the impact of the preferred treatment.

3.1 Age In the same age group, there is no significant difference in preference for treatment between psychological counseling and psychotherapist practitioners in the A/B/C cities compared to those in the younger age group. For the middle age group, the proportion of psychoanalysis in the first-tier cities (24.0%) is larger than that in the B-layer cities 12.9%. For the high age group, the proportion of people who prefer cognitive therapy in layer A (34.9%) is smaller than that in layer C (55.8%). The proportion of people who prefer psychoanalysis in layer A and B

(20.6% and 17.6% , respectively) is larger than that in layer C (2.3%) . After the combination of practitioners’ system analysis, across the three age groups, the medical system shows no significant difference; 42.4% and 42.1% in the low age group. The proportion of people who choose cognitive therapy first is 58.4% , whereas the proportion of people who prefer psychoanalysis (4.4%) is smaller than that in the middle age group (13.5%) . The proportion in the low age group (8.0%) is smaller than in the middle age group (25.7% and 22.6%) . The proportion of people who prefer behavioral therapy in the middle age group is

(6.6%) , which is larger than that in the high age group (0.8%) . The practitioners who prefer cognitive therapy and psychoanalysis in the low age group are 4.018 times of the practitioners in the middle age group. The practitioners in the low age group prefer general psychological treatment. Additionally, in terms of preference for cognitive therapy, their probability is one-tenth that of practitioners who are over the age of 30. Furthermore, practitioners aged 31 to 39 years prefer integrative therapy and cognitive therapy. The probability of preferring is approximately one-quarter that of the other age groups.

Table 2 Psychological counseling and psychological treatment practitioners’ treatment orientation and the relevant factors in the likelihood ratio test (with cognitive therapy and psychoanalysis as references)

Effect	Model Fit Criteria		Likelihood ratio test	
	The 2-fold log-likelihood of the simplified model		<i>df</i>	<i>P</i>
Constant term	3 148.224	0.000	0	0.000
Age (ungrouped)	3 159.476	11.251	10	0.338
Working time (ungrouped)	3 162.221	13.997	10	0.173
Continuing education hours (ungrouped)	3 158.767	10.543	10	0.394
1 (Zone)	3 167.096	18.872	10	0.042
2 (Zone)	3 171.571	23.346	10	0.010
3 (Zone)	3 178.159	29.935	10	0.001
4 (Zone)	3 181.024	32.800	10	0.000
5 (Zone)	3 189.224	41.000	10	0.000
A layer of the city	3 168.785	20.561	10	0.024
B layer of the city	3 163.639	15.415	10	0.118
Educational system	3 177.543	39.318	10	0.001
Medical system	3 169.246	21.021	10	0.021
Gender	3 177.856	29.632	10	0.001
Age ≤30 years old	3 177.856	16.515	10	0.086
Age 31 – 39 years old	3 549.999	19.460	10	0.035
College degree or below	3 160.986	12.761	10	0.237
Master’s degree	3 173.962	25.737	10	0.004
Doctoral degree	3 168.653	20.429	10	0.025
Psychological background	3 167.492	19.268	10	0.037
Medical background	3 163.782	15.558	10	0.113
Pedagogical background	3 163.782	20.454	10	0.025
Other professional background	3 165.232	17.008	10	0.136
Employed ≤3 years	3 163.110	14.886	10	0.074
Employed 4 – 6 years	3 166.976	18.752	10	0.044
Supervisory guidance	3 169.828	12.270	10	0.017

3.2 Gender Among the practitioners, 70.2% (*n* = 7 780) are female and 29.8% (*n* = 3 310) are male. The proportion of females is significantly larger than that of males. This result is consistent across districts, cities, and practitioners. In C-layer city, males account for 41.7% , which is significantly larger than the proportion in A-layer cities (29.0%) and B-layer cities (26.7%) . The proportion of 22.3% in the educational system is significantly smaller than that in both medical and other social practice systems (35.1% and 32.3%) . Women show an opposite trend. Hypnotherapy and cognitive therapy are preferred among male practitioners. The probability of hypnotherapy being the first choice and a preference for psychoanalysis among male practitioners is 26 and 20 times higher than that among female practitioners ,

respectively. That is, male practitioners have a significantly greater probability of preferred hypnosis therapy.

3.3 Educational background Among the practitioners, 15.0% (*n* = 1 790) are college graduates, 53.0% have an undergraduate degree (*n* = 6 320) , 28.1% have a master’s degree (*n* = 3 350) , and 3.9% have a doctoral degree (*n* = 470) . Comparing the educational background across the six administrative regions, the proportion of those who had tertiary education and the following academic qualifications in Zone 5 (Northwest) is the largest (21.5%) . The largest proportion of practitioners with a master’s degree (41.1%) and doctoral degree (7.4%) is in Zone 1 (Northeast) . In the urban stratified analysis, in C-layer cities, the proportion of practitioners with tertiary education and below is

22.6% , which is significantly larger than that in A-layer cities (12.4%). In B-layer cities, the proportion of cities is 66.7% . Additionally, in C-layer cities, the proportion of practitioners with an undergraduate degree (69.4%) is significantly larger than that in A-layer cities (43.3%). Regarding urban master's degrees, the proportion in A-layer cities (38.3%) is significantly larger than that in B-layer and C-layer cities (14.6% and 8.1%). In C-layer cities, no practitioner have a doctoral degree. In A-layer cities, the proportion of practitioners with a doctoral degree is 6% , which is significantly higher than that in B-layer cities (1.1%). According to the practitioner system analysis, in terms of the education system, the proportion of practitioners with college education and below is 5.7% , whereas 43.6% have an undergraduate degree. The proportion of practitioners with educational level of junior college and below is 5.7% and the proportion of practitioners with an undergraduate degree is 43.6% . The proportion of other social practitioners with college education and below is 22.7% and the proportion of other social practitioners with undergraduate degree is 57.9% . The proportion of practitioners with a master's degree (46.5%) is significantly larger than that in the medical system and other social practitioner systems (19.1% and 17.8%). In the medical system, the proportion of practitioners with a doctoral degree (6.0%) is significantly larger than that in other social systems (1.6%). Practitioners with a doctoral degree prefer CBT and cognitive therapy or CBT and psychoanalysis, with a 4.6-5-fold probability higher than practitioners without a doctoral degree. Furthermore, practitioners with a doctoral degree also have an increased probability of preferring behavioral therapy. Practitioners with a master's degree also have an increased probability of choosing CBT.

3.4 Working time There is no difference in the average practitioner working time across the six administrative regions ($n = 15.597$, $P = 0.008$). There is also no difference in the average time spent on working by practitioners in the stratified cities ($P > 0.05$). The average working time of the three practitioners differ ($n = 26.399$, $P < 0.001$). Using the K-S one-sample test and a significance level of $P < 0.001$, it is found that the practitioners' data do not meet the normal distribution of time or Levene's test of the homogeneity of variance with a significance level of $P > 0.05$.

However, after a variety of changes in working time, it still does not meet the conditions of a normal distribution. Therefore, the frequency distribution of working time (< 3 years), medium time group (4–6 years), long time group (> 7 years) is created. After grouping, there are 4 580 (37.8%) in the short time group, 3 760 (31.0%) in the medium time group and 3 770 (31.09%) in the long time group. Comparing the stratum of the three cities and the proportion of the practitioners in the three working time groups in the three urban strata, the proportion of C-layer cities (50.4%) and other social practitioners (43.3%) are the largest, whereas the medical system (40.8%) of the long-time practitioners is the largest in the proportion of the time group. Practitioners with < 3 years of practice have a decreased probability of preferring behavioral therapy and integrative therapy. Practitioners with 4–6 years of experience are 1.97 times more likely to prefer cog-

nitive therapy and psychoanalysis than other practitioners. At the same time, these practitioners have a decreased probability of preferring psychoanalysis, behavioral therapy and sand table therapy.

3.5 Professional background Practitioners with a psychological background prefer hypnosis therapy and psychoanalysis. Practitioners with a medical background have a decreased probability of preferring cognitive therapy and increased probability of preferring psychoanalysis and family therapy. Practitioners with a pedagogical background have an increased probability of preferring family therapy and decreased probability of preferring integrative therapy. Practitioners with other professional background have a lower probability of preferring behavioral therapy and integrative therapy.

3.6 Supervision and guidance Among the practitioners, 35.9% ($n = 4\ 340$) are unsupervised, whereas 64.1% ($n = 7\ 560$) are supervised and instructed. In a comparison of six districts' practitioners with and without the supervision of proportion, Zone 4 (East China) has supervised proportion of 72.5% that is larger than Zone 5 (Northwest) (57.0%). In a comparison of the three systems' practitioners, in the education system (38.4%) and medical system (41.6%), the proportion of persons without supervision is significantly larger than that in other social systems (27.3%). Unsupervised counseling increases the probability of preferring cognitive therapy, CBT, and hypnotherapy and decreases the probability of preferring psychoanalysis.

The differences between men and women are significant, especially for female practitioners. They differ significantly between urban stratification and practitioner systems, indicating that the level of socioeconomic development and the practitioner system have a significant impact on the choice of treatment for female practitioners.

3.7 Urban stratification and practitioner system In different urban strata, cognitive therapy and behavioral therapy are the most commonly used therapies among practitioners. Nevertheless, the proportion in A-layer cities (56.3%) is smaller than that in B-layer (62.4%) and C-layer (66.2%) cities. In A-layer cities, the proportion of practitioners who prefer psychoanalysis (34.3%) is larger than that in B-layer cities (25.7%) and C-layer cities (12.3%) by almost three times. A-layer cities, in which practitioners often use party-centered therapy (19.1%) and (CBT 17.4%), have a larger proportion of persons who frequently use home treatment (14.9%) as the fourth and fifth conventional therapy. In B-layer and C-layer cities, the proportion of people who use household therapy is often larger than that in the other two, especially C-layer cities, and the proportion of people who frequently use home remedies (17.7%) is higher than that of people who use the usual psychoanalytic therapy (12.3%).

The ranking of the preferred therapies in the various systems is close to that of the national trend but also has its own characteristics. The education system prefers CBT compared to the preferred psychoanalysis. The medical system prefers sand table therapy to a lesser extent compared to the national level. The other social practice systems prefer integrative therapy to a greater extent than the national level (Table 3).

Table 3 Preferred therapies of practitioners in the three practitioner systems

Name of therapy	ED	MD	OD
	[a] (n = 4 080)	[b] (n = 3 740)	[c] (n = 3 840)
Cognitive therapy	1 950 (47.8)	1 570 (42.0)	1 350 (35.2)
Psychoanalysis	410 (10.0)	620 (16.6)a	810 (21.1)e
CBT	470 (11.5)	540 (14.4)	200 (5.2)
Behavioral therapy	320 (7.8)	250 (6.7)	180 (4.7)
Client—centered therapy	200 (4.9)	100 (2.7)	180 (4.7)
Integrative therapy	140 (3.4)	110 (2.9)	200 (5.2)
General psychotherapy	120 (2.9)	140 (3.7)	110 (2.9)
Sand table therapy	100 (2.5)b	10 (0.3)	180 (4.7)b
Family therapy	40 (1.0)	70 (1.9)	100 (2.6)
Hypnotherapy	20 (0.5)	50 (1.3)	120 (3.1)a
Other therapies	310 (7.6)	280 (7.5)	410 (10.7)

Regarding the impact of urban stratification and practitioner systems on the preferred therapy, the A/B/C layer of ten kinds of therapy are entered into the test. In the other social practitioner systems, a layer of urban practitioners prefer psychoanalytic therapy to a greater extent than the C layer (23.6% and 7.5%). In B-layer cities, the education system of choice for psychoanalysis (5.8%) is

less than that for other social system practitioners (22.4%).

3.8 Practitioners' zone There are significant differences in the first choice of practitioners in the six administrative regions of the country. The proportion of practitioners whose first choice is cognitive therapy in Zone 1 is significantly larger than that in Zone 2 (33.7%), Zone 3 (36.5%) and Zone 4 (33.9%). The proportion of practitioners who prefer CBT (4.5%) is significantly smaller than that in Zone 4 (14.5%) and Zone 5 (13.3%). The proportion of 24.3% is significantly larger than the proportion in Zone 5 (10.7%) and Zone 6 (10.9%). The higher the level of psychological education, the more the psychological counseling agencies and the more the practitioners^[11]. Since the current psychological counseling and treatment in terms of price and demand are still luxury consumer goods^[3], it can be inferred that when a region's economic development level is relatively low, the psychological counseling and treatment industry might be in the early stages. The local psychological counseling and treatment industry has early characteristics. Given that it started in the hospital, more practitioners have a medical background and a low level of education. The proportion of practitioners with medical background in the six zones is the largest. Additionally, the proportion of practitioners with college education and below is the largest (Table 4).

Table 4 Practitioners' gender, age, education, working time, professional background and supervision in the three different layers of urban stratification and three practitioner systems

	Urban A layer[a]	Stratification B layer[b]	C layer[c]	ED[d]	Practitioner MD[e]	System OD[f]
Gender						
Female	5 180(71.0)e	2 690(73.3)	770(58.3)	3 240(77.7)ef	2 530(64.9)	2 700(67.7)
Male	2 120(29.0)	980(26.7)	550(41.7)eb	930(22.3)	1 370(35.1)d	1 290(32.3)a
Age						
Age ≤30	2 020(28.1)	830(22.9)	310(24.2)	1400(34.2)ef	790(20.5)	920(23.3)
Age 31 – 39	3 020(42.0)	1 570(43.4)	530(42.4)	1 600(39.1)	1 720(44.7)	1 720(43.7)
Age ≥40	2 150(29.9)	1 220(33.7)	440(34.4)	1 090(26.7)	1 340(34.8)a	1 300(33.0)
Educational background						
College degree or below	880(12.4)	2 380(66.7)e	280(22.6)e	230(5.7)	650(17.0)a	880(22.7)a
Undergraduate	880(12.4)	1 040(53.3)	1 020(53.4)	1 760(43.6)	2 210(57.9)d	2 240(57.9)a
Master	2 730(38.3)bc	520(14.6)	100(8.1)	1 880(46.5)ef	730(19.1)	690(17.8)
Doctor	430(6.0)b	40(1.1)	0(.0)	170(4.2)	230(6.0)f	60(1.6)
Working time						
<3 years	2 520(35.0)	1 400(38.9)	660(50.4)e	1 610(38.9)	1 210(31.7)	1 700(43.3)e
>4 – 6 years	2 320(32.2)	1 200(33.3)	410(31.3)	1 320(31.9)	1 050(27.5)	1 290(32.8)
≥7 years	2 360(32.8)	1 000(27.8)	540(27.7)	1 210(29.2)	1 560(40.8)af	940(23.9)
Professional background						
Medical background	2 490(34.3)	1 520(41.8)e	420(32.1)	570(13.8)	3 210(82.3)ac	600(15.2)
Pedagogy	1 180(16.2)	650(17.9)	330(25.2)e	1 190(28.7)ec	140(3.6)	750(19.0)b
Other professional background	1 770(24.3)	870(23.9)	340(26.0)	890(21.5)b	220(5.6)	1 830(46.3)ab
Psychological	3 880(53.4)b	1 590(43.7)	640(48.9)	2 510(60.6)bc	1 550(39.7)	1 890(47.8)
Supervision guidance						
No	2 060(28.7)	1 580(43.4)a	700(54.3)a	1 590(38.4)f	1 600(41.6)f	1 060(27.3)
Yes	5 110(71.3)bc	2 060(56.6)	590(45.7)	2 550(61.6)	2 250(58.4)	2 820(72.7)de

Note: ED: educational system, MD: medical system, UD: other practitioners of social systems; the letter with the subscript indicates that the constituent ratio of the column is larger than that of the column represented by the subscript letter (a' = 0.5 ÷ 15 = 0.003 3); professional background is multi-optional.

4 Discussions

Why do Chinese psychological counseling and treatment practitioners choose "classic" therapy most often?

China's traditional medicine called "idea therapy" starts with the patient's psychology through the adjustment of his or her mental

state to achieve the purpose of treatment. Such therapy includes changing the patient's cognition, behaviors and emotion. Many technologies coincide with some modern cognitive or behavioral therapy technology. For example, in A-layer and B-layer cities, (To page 42)

and strictly stop violations of the legitimate rights and interests of farmers. (iii) We should establish the land circulation investment platform and include land circulation projects in the unified investment platform of the whole county. The investment platform is responsible for integrating the information of land to be circulated, carrying out special promotion and investment invitation according to the target market, guiding the major growers and farmers' cooperative organizations to actively participate in the land circulation, introducing leading enterprises and investors into the land circulation market, and forming a rational land circulation pattern.

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psychological counseling and psychotherapy practitioners prefer cognitive therapy to a lesser extent, and the probability of their preferring psychoanalysis is high. In addition, based on the overall trend, A-layer cities prefer the treatment trend and are completely consistent with the national trend. B-layer cities prefer the treatment trend, with some inconsistencies, whereas C-layer cities show obvious inconsistencies. This also reflects the socioeconomic and cultural level of the development of the psychological treatment industry impact. Therefore, if cities with different economic levels are not studied separately, they cannot truly address the status question. For example, if only most convenient cities are sampled, the real situation in medium-developed areas and, especially underdeveloped areas, will not be demonstrated.

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