The Journal of Sociology & Social Welfare

Volume 4
Issue 5 *May*

Article 10

May 1977

Observations on an Emerging Profession

Lincoln J. Fry
Ventura Region Criminal Justice Planning Board

Jon Miller
University of Southern California

OBSERVATIONS ON AN EMERGING PROFESSION

Lincoln J. Fry
Ventura Region Criminal Justice Planning Board

Jon Miller
Laboratory for Organizational Research, University of Southern California

ABSTRACT

This study examines the ranking that rehabilitation counselors received from their colleagues and clients in an alcoholism rehabilitation organization. The findings suggest that organizational power was the major determinant of the favorable ranking rehabilitation counseling received from colleagues; legitimacy appeared to accrue from power, not the reverse. Occupational visibility appeared to account for client ranking while knowledge that a powerless client group was controlled by others was found to be an important dimension of rehabilitation counselor standing with clients. One implication of the study is that the immediate social environments of occupations provide a meaningful place to begin to document the professionalization process.

A persistent concern in the study of the professions has been to determine what distinguishes them from other occupations and to establish benchmarks which specify how occupations become professions. It has been suggested that more attention be given to the immediate social environments of occupations (Grimm and Kronus, 1973; Blankenship, 1973). Two groups in the occupational environment, clients and colleagues, have received the bulk of this attention (Haug and Sussman, 1969; Blankenship, 1973; Grimm and Kronus, 1973). The present study continued this emphasis by exploring the relationship between the career contingencies of a single occupation, rehabilitation counseling, and its social standing with clients and colleagues in an alcoholism rehabilitation organization. Our purpose was to assess the role of clients and colleagues in the professionalization process and to discuss some of the problems that might face similar occupations in their quest for professional status.

To preview our findings, we found that both clients and colleagues were important factors in the identity that rehabilitation counselors assumed, but that they formed their impressions and made their influence felt in quite different ways. These differences were due in large part to the organizational surroundings that formed the backdrop for the work of the counselors. Before we discuss our find-

ings in detail, the problems we studied should be given some theoretical focus.

VIEWS OF PROFESSIONALIZATION

Some of the lack of clear direction in the study of professions may be attributed to the fact that they have been approached from two distinct theoretical perspectives. One approach is normative and visualizes occupations as professions to the extent that they conform to certain core characteristics contained in an ideal-typical model (Hughes, 1958; Goode, 1961).[1] The second approach assumes that profession is primarily a label occupations apply to themselves in order to gain or show evidence of power and prestige (Sussman, 1966; Roth, 1974). Ordinarily, the normative perspective has been concerned either with attitudes toward professionalism held by occupational members or the way the general public perceives the social standing of various occupations. Most research efforts have reflected the latter concern, resulting in broad social stratification studies which present the prestige rankings of a large number of occupations along a continuum of professionalism (Hodge et al, 1964). By way of contrast, the power approach has stressed an historical perspective, emphasizing the need to analyze the devices occupations use to acquire and legitimate their positions in the occupational structure, with special attention given to structural supports such as licensing, which allow occupations to mandate their own professionalism (Roth, 1974).

Several attempts have been made to include both attitudinal and structural elements within a single framework (Wilensky, 1964; Hall, 1968). However, Hall (1968) is led to conclude from his study that the strucutral elements associated with professionalism are not systematically related to attitudes toward professionalism, an indication that the effort to synthesize the two approaches has not been particularly productive. Divergence is apparent as to how the study of the professions should proceed,[2] yet organizations as the immediate environments of occupations are increasingly identified as the place to begin to unravel the professionalization process (Glaser, 1968; Grimm and Kronus, 1973).

Glaser (1968) describes organizations as vehicles which provide a base or foothold from which persons are able to develop strategies for managing their respective career concerns. From this perspective, organizational affiliation is seen as the mechanism linking an individual to an occupational community. By way of contrast, it should be pointed out that this notion that organizations provide a means to launch a professional career stands in stark opposition to a large volume of literature devoted to what is known as the professional-

organizational dilemma (Blau and Scott, 1962; Abrahamson, 1967). The general conclusion to be drawn from this research is that professions and organizations are not compatible. Etzioni (1964), for one, has stated that certain occupations have not or will not reach full professional standing because the bulk of their work activities are conducted under the jurisdiction of large bureaucratic organizations. Included in the list of occupations which suffer from this organizational stigma are nurses, teachers and social workers. Glaser's (1968) counter to this argument is that professionals must engage in organizational careers, especially because more and more occupations perform their work tasks under the aegis of organizations, resulting in professionals now displaying positive orientations toward both their occupations and their employing organizations.

Those who emphasize the environmental aspects of occupations stress the need to specify the elements in organizational surroundings which impinge upon the professionalization process. Occupational "publics" have been identified as potential sources of prestige and power for occupations. Haug and Sussman (1969), for example, suggest that "segmental publics" are necessary to evaluate an occupation's prestige rating, specifically because of the specialization that characterizes the modern labor force. Not all occupations are equally known to all members of a society and occupations are only "visible" to certain segments of the population. Because of this, these select groups are the most salient in assessing the standing of an occupation, especially clients and colleagues. They did find differences in the ratings that rehabilitation counselors received which were strong enough to conclude that clients and colleagues do define the professional, but in divergent ways. They also concluded that uniformed stereotyping is more likely to form lay opinion of an occupation than is varying degrees of exposure to that occupation. Despite some problems in interpretation, Haug and Sussman's (1969) work appears to be the single empirical study which has attempted to assess the role of clients and colleagues in the professionalization process. Others have also addressed this problem, but in theoretical terms only (see Blankenship, 1973; Grimm and Kronus, 1973).

Rehabilitation counseling is an occupation which specializes in counseling the physically and mentally disabled. Like the majority of the newer paramedical occupations, rehabilitation counseling is a civil service occupation practiced in large bureaucratic settings, thus receiving a great deal of governmental support. Haug and Sussman (1969) suggest that this factor alone has placed rehabilitation counseling in a higher prestige position sooner than would be expected through the usual process of earning status by provision of a needed service. More important for our purposes, they also noted that those who had

direct knowledge of the work of rehabilitation counselors gave them higher prestige ratings. Yet the effect of this visibility was unclear. While the prestige scores for rehabilitation counselors increased beyond chance expectations, with knowledge of rehabilitation counselor work activities, this familiarity also shifted the evaluation of all the helping professions included in the study upward, with no change in the relative position of rehabilitation counselors. Further, it was unclear in their study as to whether respondents actually had contact with the work of rehabilitation counselors. To illustrate the problem, friends, co-workers and relatives of the disabled were all included in an "exposure to disability" category. It is clear that the issue of visibility and knowledge of work tasks of rehabilitation counselors need to be re-examined in a more carefully defined environment. This line of investigation is taken in this study.

BACKGROUND OF THE STUDY AND THE SETTING

The study took place within the alcoholism treatment system of a large California county. This organization had been created to conform to a major piece of state legislation which allocated money to counties for the development of "comprehensive" alcoholism treatment networks. The state department of rehabilitation cooperated in these local ventures, providing administrative liaison with the state capitol as well as providing salaries for certain personnel, specifically rehabilitation counselors, part-time physicians for physical examinations and some clerical staff.

The treatment staff that we studied consisted of four separate clinics, staffed by five interdisciplinary teams. Each of these teams included a rehabilitation counselor, a social worker, a nurse and a public health investigator. The salaries for team members, other than the state-paid rehabilitation counselors, were provided out of county monies. Some teams had more than one member from the same discipline, for example, graduate students in social work, psychology and counseling, who were employed on a part-time basis. All of the clinics were located in urban areas. One clinic had two treatment teams and also housed the system's administrative component; another was located in a skid row mission; one was in a county health facility in a ghetto area; and one was in an industrialized waterfront community.

An earlier phase of the study consisted of participant observation and began when personnel were being recruited to staff the skid row clinic. The mission that housed this clinic was run by a large, international, religious-philanthropical organization; in this setup the team treatment method had to co-exist with the religious group's more traditional approach. Most of the participant observation efforts, which went on over two years, were confined to analyzing the services

that were developed in this setting. An earlier paper has described these services in detail and characterized them as ineffective and generally alienating to the mission population (Fry and Miller, 1975). Ambiguous and competing goals, conflicting vested interests of participants, conflicts over resources, and a lack of an effective treatment technology were identified as major contributors to this failure. Also important was a lack of planning, especially the failure to determine what kind of treatment services mission patients wanted to receive.

The observational phase of the study also attempted to assess the impact of interdisciplinary teams on the members of the entire treatment system (Fry and Miller, 1974). The implications of the team approach for treatment personnel were confounded because of the superordinate role rehabilitation counseling came to possess within the treatment system. Role negotiation, a basic tenent of team treatment, was found to be virtually non-existent because the teams were dominated by the rehabilitation counselors. The first members hired, rehabilitation counselors had the most discretion in deciding the composition of their teams. Most important, they had primary control over the system's financial resources. One surprising finding was the extent to which administrators were disadvantaged by the team method. Their major work roles had been usurped by the teams which theoretically developed their own leadership structures. However, while these earlier investigations clarified some of the problems and conflicts in the treatment system, they left unanswered the standing of rehabilitation counselors with their team colleagues from other disciplines and with their clients.

METHOD

Based upon the impressions gathered during this observational phase, questionnaires were administered to two distinct populations in the system. The first was administered to 39 residents of the skid row mission who had been accepted as clinic patients. Of these, 30 questionnaires were completed and our findings on client perceptions of rehabilitation counselors were based on this instrument. The second instrument was administered to all 62 members of the alcoholism organization. Of these, 59 were returned completed and these responses formed the basis for colleague perceptions.

The client questionnaire was designed to replicate some of the Haug and Sussman (1969) findings. Their research was based on a national probability sample of 1,526 respondents collected by the National Opinion Research Center (NORC), in 1966. Respondents were asked to rate seven rehabilitation occupations and five other professions used in the 1947 and 1963 NORC studies. The 1966 study included questions designed to measure knowledge about rehabilitation counsel-

ing and made no inquiry about the nature of any other occupation.

Our client instrument used a different method to generate occupational rankings than had been used in the Haug and Sussman (1969) research. They used the standard NORC method which asks respondents to rate occupations from poor to excellent, with 100 points possible for an occupation that only receives excellent ratings. We asked the skid row respondents to assign numbers to occupations on a scale from 0 to 100. This method was used because the occupations included in the client questionnaire were all fairly high status occupations, presenting the possibility that little variation would appear, especially because of our small sample size. Besides requests for basic demographic information and opinions about their own drinking problems, the client instrument contained open-ended questions which asked respondents to describe in detail the work tasks rehabilitation counselors performed, to identify their sources of this knowledge, specifically in terms of whether anyone had ever given them a detailed description of these tasks and where they were when they received this information. A final question asked them to identify the occupational group which they felt was best qualified to treat problem drinkers, even if they did not feel that drinking was their major problem.

The colleague questionnaire contained sociometric questions to measure prestige, control, friendship choices and work contacts. Scores were recorded so that it was possible to determine the number of sociometric responses members of each occupational category gave to each other as well as to other occupational groupings. Prestige was measured by the number of times an individual was named in response to the question, "Of all the people you work with, please list the five whose opinion of your work you respect most highly...". Control was determined by the number of times a person was mentioned in response to the question, "...please give the names and position of the five people in your department (organization) who you feel actually have the most to say about how the department (organization) is run". Friendship status was measured by the number of times a person was named in response to the question, "Of all the people whom you know at work, who are your close friends?" Finally, work contact was measured by the number of times a person was mentioned in response to the following question, "Please think of (list) the five people in the organization with whom you have worked most closely in the past month".

FINDINGS

Client Perceptions Table 1 displays the ranks our skid row subjects assigned to specific occupations as compared to the "exposure to disability" category included in the Haug and Sussman (1969) study. In

that study, this subsample was dichotomized into those who had knowledge of the work of rehabilitation counselors and those who did not have this knowledge (labeled "yes" and "no", respectively, under "knowledge of tasks" in Table 1). Table 1 reveals some of the problems of interpretation mentioned earlier. For example, those in the "no" category assigned the occupation a score of 78 and those in the "yes" category a score of 83. While this difference was statistically significant, rehabilitation counseling only improved a single rank, from sixth to fifth, and all of the scores in the "yes" category improved for all occupations. In comparison, rehabilitation counseling in our study did receive a rank similar to that found in the exposure to disability category with knowledge of the tasks rehabilitation counselors performed, 4.5. However, the greatest divergence in the table is the rankings these skid row patients assigned to psychiatrists and occupational therapists. It is not clear how these differences should be interpreted.

TABLE I

COMPARISON OF RATINGS OF SEVEN REHABILITATION RELATED OCCUPATIONS: BETWEEN NORC SAMPLE WITH EXPOSURE TO DISABILITY WITH AND WITHOUT KNOWLEDGE OF REHABILITATION COUNSELOR TASKS AND PATIENTS OF SKID ROW ALCOHOLISM CLINIC (N=30)

	*Exposure to Disability Sample					
	Knowledge of Tasks					
	No		Yes		Skid Row Patients	
Occupation Rated	Score	(Rank)	Score	(Rank)	Score	(Rank)
Physician	92	(1)	93	(1)	97	(1)
Nurse	83	(2)	85	(2)	86	(2)
Psychiatrist	81	(5)	82	(6)	82	(3)
Clinical Psychologist	82	(3.5)	84	(3.5)	81	(4.5)
Occupational Therapist	82	(3.5)	84	(3.5)	76	(6)
Rehabilitation Counselor	78	(6)	83	(5)	81	(4.5)
Welfare Social Worker	71	(7)	72	(7)	73	(7)

* Partially reproduced from Haug and Sussman (1969:61)

What is clear is that the variation in the ranking rehabilitation counseling received was interpreted by Haug and Sussman (1969) to result from differences in knowledge of work tasks performed. However, when the responses to the question which asked our skid row subjects to describe the work rehabilitation counselors perform were tabulated, none of them accurately described these tasks. Nine individuals indicated they were unable to answer the question, while the remainder

(21 individuals) gave a description which was generally inaccurate in terms of the way the alcoholism organization defined these duties. An example of the way organizational environments affect occupations, the system defined rehabilitation counselor duties as "the improvement of social functioning prior to vocational considerations". As a group, rehabilitation counselors made a clear distinction between their occupation and vocational counselors, defining their own duties primarily as counseling and downgrading the vocational aspects of their work; job developers were charged with employment placement responsibilities within the system. At training sessions, the supervising rehabilitation counselor stressed that the counseling role should be emphasized to patients at the time of first contact. Yet the only pattern which appeared in the descriptions of duties was related to vocational considerations; several respondents mentioned employment, typically stated as "to get me a job", while no description of rehabilitation counselor duties mentioned counseling. Perhaps what is more important, 23 respondents indicated that no one had ever explained to them what work tasks rehabilitation counselors were supposed to perform. As a result, the similarity in ranking that rehabilitation counselors received in Table 1 cannot adequately be accounted for by knowledge of work tasks. Our suspicion is that sheer visibility alone explains these findings; these skid row patients were all officially clients of a rehabilitation counselor and therefore had some contact with them. While they did not know what tasks this occupation was mandated to perform in the treatment system, it appears, as suggested by Haug and Sussman (1969), that an occupation's service may be evaluated without using a clear work task criterion.

Another tentative answer to the question as to how patients evaluated the services provided by rehabilitation counselors is presented in Table 2, where the responses to the question which asked skid row patients to list the occupation most qualified to treat problem drinkers are listed.

TABLE 2

PATIENT PERCEPTIONS OF THE GROUP BEST QUALIFIED TO TREAT PROBLEM DRINKERS (N=30)

Occupation	N	(%)
Physicians	14	(47)
Ministers	3	(10)
Nurses	2	(07)
Rehabilitation Counselors	1	(03)
Psychologists	1	(03)
The Clinic Team	1	(03)
Alcoholics Anonymous	2	(07)

The Clinic as a Whole		5	(17)
Self		1	(03)
	Total	30	(100)

Mission patients clearly chose physicians as the occupational group most qualified to treat problem drinkers. There was no obvious second choice, while rehabilitation counseling received only a single nomination. These respondents, all clients of a rehabilitation counselor, gave that occupation a rating which was equivalent to the ranking received from those who were familiar with the work of rehabilitation counselors in the Haug and Sussman (1969) study. Yet that rating, which was interpreted to be an improvement over the general standing of rehabilitation counselors, was not explained here by client knowledge of work tasks. Visibility without clear evaluation criteria, appeared to account for rehabilitation counseling ranking. Further, clients did not perceive rehabilitation counselors as the occupation most qualified to treat them. How the mission environment may have affected patient perceptions is addressed in the discussion of the findings.

Colleague Perceptions Returning to the issue of the standing of rehabilitation counseling with colleagues, Table 3 represents the results of the tabulation of the indicators of sociometric choices. Of those occupations which provided members for the interdisciplinary teams, rehabilitation counselors received the largest mean number of prestige nominations, 6.4 nominations per counselor. Prestige nominations appear to be the most meaningful indicator of professionalism among these measures. This occupation also received the highest average number of control and friendship choices and was about equal to social workers in terms of work contacts received per member of these two disciplines. It was also apparent that administrators and supervisors were seen as controlling the alcoholism organization, with 19.1 control choices per member of this group, and that they enjoyed a high level of prestige, an average of 10.8 nominations for each member.

One consideration in the analysis of the sociometric choice pattern was the extent to which these responses were vertical or horizontal in nature; that is, were respondents likely to cast their nominations for individuals with similar occupational status within the organization or were they likely to choose members higher or lower in the occupational hierarchy? Table 4 displays the percentage of sociometric choices members of the alcoholism organization received from each of three occupational groupings; administrators and supervisors, treatment personnel, and clerical and social service aides.

A sharper picture of the structure of the alcoholism organization begins to appear in this table. Administrators and supervisors were

TABLE 3

MEAN NUMBER OF CHOICES RECEIVED ON SOCIOMETRIC INDICATORS OF ORGANIZATIONAL PRESTIGE, ORGANIZATIONAL CONTROL, FRIENDSHIP CHOICES, AND WORK CONTACT FOR VARIOUS ORGANIZATIONAL PERSONNEL (N=59)

	Administrators & Supervisors (n=8)	Rehabilitation Counselors (n=5)	Social Worker (n=7)	Nurses (n=11)	Public Health Investigators (n=6)	Miscellaneous[a]	Clerical & Soc. Serv. (n=16)
Mean No. Prestige Choices Received	10.8	6.4	4.1	2.8	2.5	3.7	1.3
Mean No. Control Choices Received	19.1	3.6	2.4	1.6	1.2	1.5	.5
Mean No. Friendship Choices Received	5.6	5.6	4.1	2.9	3.2	4.0	1.7
Mean No. Work Contact Choices Received	6.1	5.4	5.3	3.9	3.7	5.0	2.3

[a] Miscellaneous professionals include some idiosyncratic occupations attached to the interdisciplinary treatment teams, for instance, a public health position, a recreation therapist, a clinical psychologist, and others.

TABLE 4

PERCENTAGE OF SOCIOMETRIC CHOICES RECEIVED BY THE ADMINISTRATIVE COMPONENT, TREATMENT PERSONNEL AND CLERICAL AND SOCIAL SERVICE AIDES CONTROLLED BY SOURCE OF THESE CHOICES (N=59)

	Source of Sociometric Choices											
	Administrators & Supervisors (n=8)				Treatment Personnel (n=35)				Clerks & Social Service Aides (n=16)			
	Sociometric Indicators											
Occupational Categories	Prestige	Control	Friendship	Work Contacts	Prestige	Control	Friendship	Work Contacts	Prestige	Control	Friendship	Work Contacts
Administrators & Supervisors	93	100	97	97	33	73	15	10	21	61	09	13
Treatment Personnel	04	00	03	03	67	27	78	85	58	37	55	62
Clerks & Social Service Aides	04	00	00	00	01	00	07	05	21	02	36	25

virtually cut off from the rest of the organization. This was true both in terms of their interpersonal choices and their work contacts. This group cast 93, 100, 97 and 97 percent of their sociometric choices for other members of the administrative component. Treatment personnel acknowledged that the organization was generally controlled by the administrative component, with 73 percent of their control choices cast for administrators and supervisors. At the same time, treatment personnel cast the majority of the prestige nominations for each other, 67 percent of their choices. The same pattern appeared on the friendship and work contact indicators, while the percentage of choices treatment personnel gave to each other was higher on these two measures as compared to the percentage of prestige choices. Clerks and social service aides displayed a pattern similar to treatment personnel. The administrative component received the highest percentage of control choices, 61 percent of those cast, while the majority of their prestige, friendship and work contact nominations went to treatment personnel; 58, 55, and 62 percent, respectively.

Because of the high percentage of sociometric choices cast by clerks and service aides for treatment personnel, it could be that the sociometric ratings rehabilitation counselors received reflected a high percentage of non-colleague choices. This was a clear possibility because of the centrality of rehabilitation counselors to the organization's basic paperwork concerns. Clerks and aides did work primarily with rehabilitation counselors to process case service monies and because of basic record keeping. As a result, Table 5 displays the mean number of prestige nominations rehabilitation counselors received, adjusted for non-colleague nominations.

TABLE 5

MEAN NUMBER OF PRESTIGE CHOICES RECEIVED BY TREATMENT PERSONNEL ADJUSTED FOR CHOICES RECEIVED FROM NON-TREATMENT PERSONNEL (N=24)

Type of Personnel	Total Prestige Choices Receiv.	Received From Non-Treatment Personnel	Adjusted No. Prestige Nomin.	Adjusted Average Prestige Nomin.
Rehabilitation Counselors (n=5)	32	8	24	4.8
Social Workers (n=7)	29	9	20	2.9
Nurses (n=11)	31	11	20	1.8
Public Health Investigators (n=6)	15	6	9	1.5

Table 5 reveals that rehabilitation counselors did not suffer a disproportionate loss in overall prestige nominations when non-treatment personnel choices are excluded. They still outdistance their nearest rival, social work, by an average of almost two prestige nominations per rehabilitation counselor, 4.8 nominations as compared to 2.9 nominations. In short, the rehabilitation counselors received the highest prestige ranking from the members of those disciplines which provided treatment personnel for the alcoholism organization. While they were the leaders on all of the dimensions of sociometric choice, their prestige rating seems important here because prestige does appear to be the most meaningful indicator of professionalism among the sociometric measures. On that basis, rehabilitation counseling may be seen as the occupation with the highest professional ranking among the treatment disciplines.

DISCUSSION AND CONCLUSIONS

The findings presented here emphasize the need to concentrate on the immediate social environments of occupations. The rankings that rehabilitation counselors received from clients and colleagues begin to take on meaning when they are interpreted in the context of the alcoholism organization. From this perspective, these findings have implications for the professionalization process and the impact of clients and colleagues on the way occupations begin to change their status.

At first glance, the skid row clinic's patients might seem to represent a unique treatment population. However, this type of patient actually accounts for a sizeable proportion of rehabilitation counselor caseloads, at least in California. The organizational arrangements which characterized the alcoholism treatment system were representative of a state-wide network. Rehabilitation counselors became heavily involved in alcoholism treatment because of the central role of the state department of vocational rehabilitation in establishing these treatment systems. Also, some counties used rehabilitation counselors in yet another arrangement, in the treatment of alcoholics in hospitals or rehabilitation centers, commonly known as "drunk farms". As a result, the interaction between rehabilitation counselors and the skid row patients takes on more general significance for the role of clients in the professionalization process.

Rehabilitation counselors did receive a ranking from the skid row patients which was equivalent to the more favorable group in the Haug and Sussman (1969) "exposure to disability" subsample. If that study may be used as a baseline, rehabilitation counselors in our study received a similar rating from their clients, yet knowledge of the work tasks did not explain these results. As we said earlier, visibility

alone appears to account for this finding, and the work setting itself is a crucial factor in determining this visibility. There was a great deal of conflict in the mission environment. More than that, the mission's administration and staff were clearly antagonistic towards the clinic. The sponsoring religious organization stressed the medical model of alcoholism treatment and requested repeatedly that a medical director be appointed to head the clinic. The team interpreted this stress upon medical treatment to mean that the mission placed little value on them as treatment personnel. The fact that patients had virtually no knowledge of the work tasks rehabilitation counselors perform is explained by the fact that the rehabilitation counselor and the rest of the treatment team spent most of their energy attempting to legitimize their services with the mission's management and staff, leaving little time to legitimate themselves with the patient population.

The skid row patients were a powerless group, dependent upon the mission staff, and indirectly, the clinic, for their tenuous existence in the mission. They were also a problem to the clinic and the mission because of their lack of enthusiasm for any of the services offered to them, regardless of the source. It is difficult to separate out all of the influences that affected patients' perceptions of the types of services they wanted to receive. Whether the mission management's stress on medical treatment was a factor in their choice of physicians as the major source of treatment or if this was truly their personal preference is unclear. It is certain that they did not see rehabilitation counseling as a primary occupation in the treatment of alcoholism.

This suggests that rehabilitation counseling could not improve its status in the eyes of these patients. Besides the fact that the services offered were not highly valued and the general antagonism expressed towards the discipline by those who controlled these patients, rehabilitation counseling was saddled with some severe work constraints imposed by the treatment system itself; the clients were not the only group confused about rehabilitation counselors' work tasks. As employees of the state department of vocational rehabilitation, the rehabilitation counselors' work goals were framed primarily in terms of vocational rehabilitation by that agency with case service monies specifically set aside for this purpose. The alcoholism organization's definition of rehabilitation counselors' work tasks stemmed from the general goals established for the teams, where all members theoretically worked toward the same purpose. These ambiguous and sometimes inconsistent work goals inadvertantly contributed to program failure. Alcoholism treatment, per se, increasingly became less important to the skid row clinic while work became the major indicator of success. The clinic and the rehabilitation counselor received pressure from the state department of vocational rehabilitation to demonstrate that they

were successful with patients, and success was ultimately defined as "work". Yet patients repeatedly failed in trial jobs because of their continued drinking. This vicious circle contributed to program failure and left the mission patients in a position where they could not see any success forthcoming from the efforts of the rehabilitation counselor and the clinic venture. Against this background, the fact that the ranking rehabilitation counseling received from these patients was not lower was a surprise.

The findings on colleague perceptions of rehabilitation counseling are more straightforward. The conditions under which the alcoholism organization was founded provided obvious structural supports for rehabilitation counseling, especially their privileged position in dispensing the organization's resources and in the selection of treatment personnel. This did cause some resentment among other members of the organization, but it was largely limited to social workers. As a group, social workers were quite similar to rehabilitation counselors in terms of educational attainment, with five of the seven social workers included in the study possessing MSW degrees (all of the rehabilitation counselors had Master's degrees). The supervising social worker appeared to be the most alienated member of the administrative component. She continually stressed the fact that social work was the only occupation represented in the team structure which was really qualified to be in private practice, emphasizing the fact that several of her charges did have clinical licenses. While social workers were concerned about the privileged position of rehabilitation counseling and recognized the struggle for status between disciplines within the organization, this was not the case with either nursing or public health investigators. The primary concern of both of these occupations was their role as team members. Team practice was generally foreign to their perceptions of their proper work role. Neither expressed any concern over rehabilitation counseling as a discipline or commented on the issue of favoritism between disciplines in the organization.

Despite the evidence of resentment towards rehabilitation counseling, this discipline gradually took on an even more dominant role in the alcoholism organization's functioning. This was especially true in the interpersonal relationships which developed among the members of the organization. The personnel devoted a great deal of attention to the quality of these relationships, with T-groups and sensitivity sessions exclusively for treatment personnel a common occurrence. A rehabilitation counselor was selected to lead these sessions at the main clinic, while a similar pattern appeared in other clinics, including the skid row mission where the rehabilitation counselor was clearly the interpersonal leader. In commenting on this assumption of interpersonal and therapeutic leadership, the supervising rehabilitation

counselor saw it as an example of how other treatment personnel had come to recognize the professional abilities of the rehabilitation counselors. However, our analysis in part disagrees with this assessment. Our interpretation is that rehabilitation counseling came to occupy an exalted position in the alcoholism treatment system because of their privileged position in controlling organizational resources. This does not reflect upon the professional qualities of rehabilitation counselors vis-a-vis the other disciplines, but it does say that differential power resulted in differential prestige for rehabilitation counselors, and not the reverse.

In summary, this study re-affirms the need to examine the immediate social environments of occupations. Organizational power was identified as a crucial factor in determining the way occupations are ranked by colleagues. While rehabilitation counselors were clearly dominant in relation to other treatment personnel, having established their power and prestige, they faired less well with clients. Occupational visibility alone, not knowledge of work tasks, accounted for what may be considered a favorable rating for rehabilitation counselors when the Haug and Sussman (1969) study is used as a baseline. Yet, clients were a powerless group, controlled by those who were antagonistic to rehabilitation counselors. This left little time for rehabilitation counselors to attempt to proselytize the client group. In the context of this mission environment, perhaps the most surprising finding was the fact that clients rated rehabilitation counselors as highly as they did. The most general implication forthcoming from the study is that organizational power is a crucial element in attempting to document the process by which occupations begin to professionalize. If one occupation has an advantage on this dimension over other occupations found in the same environment, this occupation will come to dominate the work setting not only in terms of power, but also in terms of professional status.

FOOTNOTES

1. While there is not general agreement as to those characteristics which should be included in the ideal professional model, among those commonly included are the following: 1) a command over a scientific body of knowledge; 2) autonomy in the performance of work tasks; 3) and a service orientation (Hughes, 1958; Goode, 1961).

2. For instance, Halmos (1970) recommends that the professions themselves should be divided into two separate categories, one defined as "personal service professions, including the clergy, doctors, nurses, teachers and social workers; the second group would include all others, defined as "impersonal service professions."

REFERENCES

Abrahamson, Mark
1967 The professional in the organization. Chicago: Rand Mc Nally.

Blankenship, Ralph
1973 "Organizational careers: an interactionist perspective". The Sociological Quarterly 14 (Winter) 88-98.

Blau, Peter and Richard Scott
1962 Formal organizations. San Francisco: Chandler.

Etzioni, Amitai
1964 Modern organizations. New Jersey: Prentice-Hall.

Fry, Lincoln J. and Jon Miller
1975 "Responding to skid row alcoholism:. Social Problems 23 (June) 1975: 675-688.

1974 "The impact of interdisciplinary teams on organizational relationships". The Sociological Quarterly 15 (Summer) 417-431.

Glaser, Barney (ed.)
1968 Organizational careers: sourcebook for theory. Chicago: Aldine.

Goode, William
1961 "Encroachment, charlatanism, and the emerging professions: psychology, sociology and medicine". American Sociological Review 25 (December) 902-914.

Grimm, James and Carol Kronus
1973 "Occupations and publics". The Sociological Quarterly 14 (Winter) 68-87.

Hall, Richard
1968 "Professionalization and bureaucratization". American Sociological Review 33 (February) 92-104.

Halmos, Paul
1970 The personal service society. New York: Schocken Books.

Haug, Marie and Marvin Sussman
1969 "Professionalism and the public." Sociological Inquiry 39 (Winter) 57-64.

Hodge, Robert, Donald Treiman and Peter Rossi
1964 "Occupational prestige in the United States, 1925-1963". American Journal of Sociology 70 (November) 286-302.

Hughes, Everett
1958 Men and their work. Glencoe: the Free Press.

Roth, Julius
1974 "Professionalism: the sociologists' decoy". Sociology of Work and Occupations 1 (February) 6-23.

Sussman, Marvin
1966 "Occupational sociology and rehabilitation".In Sociology and Rehabilitation, Marvin Sussman (ed.) Washington,D.C. American Sociological Association: 179-222.

Wilensky, Harold
1964 "The professionalization of everyone?" American Journal of Sociology 70 (September) 137-158.