The position of nurse practitioners today comes with considerable autonomy in the expansive healthcare sector. The duties and practices that are given to nurse practitioners parallel that of a doctor and their demonstrated expertise explains why these practitioners have a chance to practice independently in 24 of the 50 United States. While not only providing accurate diagnoses and treatments, NPs foster that patient connection which often seems lost at the hands of a modern-day physician like that of a general medical practitioner or a more specialized surgeon. The insight into the development of this profession and its essential role in standardizing education, collective work, establishing a patient-provider connection, and tackling public health crises is revealed through a psychological and socially demanding perspective on a wide historical spectrum.

The role of the NP which initially began in the 1960s has expanded dramatically around the world and resembled a unique psychological maturation unseen in other healthcare professions. The 1960s was a time defined by considerable socio-economic inequities. As exemplified in Rosemary A. Steven, *Health Care in the Early 1960s*, there were “40 to 50 million citizens who were poor, who lacked adequate medical care, and who were socially
invisible to the majority of the population” (Stevens 13). Given that the historical poverty which reverberated within the nation in the 20th century was a necessary crisis that required a “different” answer, the NP was considered to be a more vital resolution to address the increasing poverty and inadequate medical care provided by money-hungry physicians. From a psychological perspective, the evolution of this new role is more fundamentally one of psychosocial growth according to Erikson’s model. Erik Erikson was a German-American psychologist who firmly established that the personality of any person is predetermined and must pass through eight different stages until their eventual demise. The stages include trust vs. mistrust, autonomy vs. shame, initiative vs. guilt, industry vs. inferiority, identity vs. confusion, intimacy vs. isolation, generativity vs. stagnation, and integrity vs. despair. These stages explain the inevitable novelty of the nurse practitioner career and how the practicality of the profession has become a question of uncertainty, medical honor, despair, shame, and even stagnation for healthcare as a whole when the public was first informed of this profession in the mid-20th century. In recognizing a formal basis for the nurse practitioner, the “infant” version is best embodied by the historic midwife. The infant nature of the midwife stems from the notion that they were initially a provider of basic care when medical knowledge and technology was historically outdated. According to Della R Sherratt, *The State of the World’s Midwifery*, “midwives were well respected in society; many having a special place in history, as can sometimes be seen in some places when reading inscriptions on headstones in ancient commentaries/burial grounds for example” (Sherratt 1). The early midwives possessed a conviction which became a routine for many women who valued the gift of motherhood and obstetric care. Therefore, the most “basic” of care was very much “respected” in any society. After acknowledging the role of the trusted midwife, there was also the limitation in regards to
the social settings that the midwife must operate within. Based on Montserrat Cabre, *Women or Healers? Household Practices and the Categories of Health Care in Late Medieval Iberia*, a large portion of the work performed by early healthcare providers was overlooked because they were restricted to the domestic sphere of the household. For instance, “any attempt to describe fully the medieval health-care system and what women contributed to it should consider that women’s health actions form a continuum that runs from ordinary to the occupational, from gratuitous therapeutic attention to paid acts of health care” (Cabré 23). This historical “continuum” explains that there was a stronger basis for the establishment of a more dignified profession since it existed for quite a long time. The extant position of the midwife coupled with the “ordinary to the occupational … paid acts of health care” re-affirms that the midwife was a fundamental stepping stone towards an elevated future in healthcare; more notably, the “infant” midwife optimistically also matured with the hope of establishing a more formal identity as a historical issue like unaffordable health care became prevalent in 1960 America.

Before explaining each stage in depth, there is a necessary purpose that the midwives must adhere to before any type of advancement can be solidified in a social setting. According to Carol Savrin, *Growth and Development of the Nurse Practitioner Role Around the Globe*, “first midwives adopted the midwifery role which was very ancient, but the concept of a trained nurse gaining additional knowledge to fill the need is relatively new” (Savrin et al., 2009). After this, there was the more advanced development of the clinical nurse specialist “which began with the purpose of improving patient care” (Savrin et al., 2009). Eventually, “the final role to develop was the nurse practitioner (NP). Interestingly, often when people speak of the advanced practice role in the United States, they are speaking of the NP role; however, NPs were the latest of the advanced practice roles to develop here” (Savrin et al., 2009). This development compares to
Erikson’s psychosocial growth because the NPs must pass through a sequential series of developmental mandates before they can progress onto the next stage. Though a distinctively “late” development, the development of this profession is one that began with a distinct purpose resting at the foundation of psychosocial growth.

In the first stage of the NP’s psychosocial development, the “child” or midwife must learn to trust the external surroundings. The NP role begins as a response to a specific demand in healthcare. Within the United States, the identified need for nurse practitioners became more pivotal in historically rural and underserved areas when physicians were not available. Midwives, in their formal recognition as “helpers,” were always secondary assistance to the higher chain of command in 19th and 20th century healthcare. This relates back to the period of trust vs. mistrust because it insinuates both the reliability of the traditional midwife and the outdated techniques they employ in healthcare with time. Subsequently, the “child” must carry out actions in which a type of autonomy is developed. With the sudden outbreak of diseases such as the HIV epidemic, a more well-rounded nurse becomes the answer. After this, the “NPs move to a new level of autonomy and begin to establish their position within a jurisdiction, but this development is not without a certain amount of dissension within the jurisdiction” (Savrin et al., 2009). When there is the establishment of some type of “autonomy”, the NP can begin to function in more expansive settings. When examining Thailand, an education program was developed for masters-prepared nurses which could educate them into becoming NPs. Historically, the standardization of education is crucial in ensuring that synchronized treatment is available to all patients. Following this, children learned to broaden their skills and gauge the possibilities of the future. The “third stage of development for the NP is expansion - the initiative to broaden the skill set, cooperative learning, and the imagination of the possibilities of the role
in the future” (Savrin et al., 2009). As mentioned before, the expansion of the skill set comes from the necessary standardization of education to ensure the practice level of NPs remains equally competent across the board and the nation. In other words, the minimum education became the Master of Science in Nursing and this minimal teaching was necessary to hold all NPs to the same level of care and accountability. In the next stage, the child learns more skills and begins to develop self-discipline. The “fourth stage of role development for the NP is consolidation of the skillset that has been developed, the formalization of the role within the medical community, and the self-regulation of the role in terms of education and policy” (Savrin et al., 2009). This stage parallels the strong discipline that the founder of nursing - Florence Nightingale - enforced on the younger nurses during the Crimean War. As outlined in Carol Helmstadter, *Class, gender, and professional expertise: British military nursing in the Crimean War,* “they were not effective nurses, Nightingale sent them home in December 1854. Miss Nightingale, the *Lancet* explained in January 1855, had already dispensed with the services of five white-veiled nuns, who proved only in the way, and were of no use as nurses in the management of sponges, bandages, wounds” (Helmstadter 32). The needed self-discipline ensures that nurse practitioners develop a self of responsibility and begin to appreciate the responsibilities they are entitled to. More importantly, the necessary routine was a strict regulation that universally prompted nurses towards professionalism regardless of the time period. Hence, the etiquette established by the founder of modern nursing became a historical impetus that would drive professionalized nursing to a much greater scale such as the development of the more qualified nurse practitioner.

In the next stage of psychosocial development, there is the crucial stage of identity versus role confusion. The hallmark of this stage is a contentious rebellion in which “children” speak
out against authority and the establishment. In the case of NPs, the “overriding purpose of statutory regulation of nursing is that of service to and protection of the public” (Savrin et al., 2009). In resisting people who speak ill of the professions, NPs are successful because they reference successful models of their work. For instance, “in the United Kingdom, probably because of its close ties to the United States, the education of the NP at the masters level has been occurring for 20-plus years, and the curriculum has paralleled that of curricular development in the United States” (Savrin et al., 2009). This challenges the pre-set understanding of nursing work and how it was often demonized because of the contentious views surrounding the “lazy” and “unqualified” nurse. According to Perry Williams’, Religion, respectability and the origins of the modern nurse, the exhausting struggle of nursing work stems from “anxiety was not on the whole about the technical competence of nurses in the manual work of patient care but about their moral standards: their taking money from patients, stealing, drinking, being dirty and untidy, and being generally of poor character” (Williams 235). Therefore, the ungoverned behavior of careless nurses strengthens the stigmas surrounding the entire profession which serve as a major hurdle in professionalizing nurse practitioners.

Ultimately, there are the last three stages when an NP has satisfaction and existential identity. In its networking and outreach capability, people from the United States are going to other nations to discuss the role of the NP. More interestingly enough, people from other nations come to the United States to understand the role of the NP. The role of the NP fits this mold when the healthcare professional is both dignified in its practice and approachable, similar to a physician. Altogether, the pre-existing models are ones that must be historically molded into more positive ones by adopting the positive aspects of the more successful nurse practitioner standards.
While there is uncertainty surrounding the last three stages of Erikson’s psychosocial model and its relation to nurse practitioners in modern times, the predominant credit is in understanding how these professionals offer higher quality treatment as part of a joint effort. The care provided by a network of nurse practitioners is something that has been clinically tested and approved by the public. According to Lawrence S. Linn's, Patient Acceptance of the Family Nurse Practitioner, a study was done in which respondents have skepticism towards nurse practitioners or physician assistants, but they still agreed to be treated by them. As mentioned, “96 percent of the patients who received health services from a team consisting of a nurse practitioner backed by a physician were satisfied with such services as compared with 97 percent who saw only a physician in a conventional arrangement” (Linn 358). Therefore, the vast network of nurse practitioners brings forth this clinical empathy which is a transient experience between patients and physicians based on visual and verbal communication. Physicians in a conventional arrangement spend minimal time with the patients and provide a course of treatment, while NPs take a longer time to address any secondary concerns the patient has. The holistic approach ensures that NPs are becoming incorporated into clinical settings and offer a more heartfelt connection with the patient that most physicians lack. Psychologically speaking, this connection resembles the closeness that many patients require at times during famines or epidemics. According to Linda Sabin’s, Sweating, Purging, and Passion for Care: The Yellow Fever Nurse in the Deep South in the Early Nineteenth Century, nurses would take on domestic and community roles. The function of “nursing was primarily domestic in nature with loved ones, friends, and neighbors helping the afflicted” (Sabin 6). Hence, comfort and care became of the utmost importance when people faced a particularly harmful disease. Eventually, the role of
the more qualified nurse practitioner shines and their presence is valued more highly given how closely they develop that connection with the patient.

Assessing the current situation of the world in a more contemporary light, COVID-19 was a difficult and modern issue in which the nurse practitioner developed even more brilliantly than before. As mentioned in W.E Rosa’s, *Leveraging nurse practitioner capacities to achieve global health for all: COVID-19 and beyond*, the article is arguing “that nurse practitioners have been under-utilized generally in the current global health environment, creating barriers to universal health coverage and the Sustainable Development goals” (Rosa et al., 1). The “sustainable development goals” are targeted to distribute healthcare workers in areas where they are deemed necessary. Altogether, the collaborative nature of the nursing profession with respect to the public health crisis is a matter of significant importance. The impetus nurse practitioners need to demand a greater level of autonomy stems from the notion that healthcare services are historically vital when seen in retrospect.

Eventually, healthcare services are just as necessary for mental health as they are for physical health. Nurse practitioners also choose to practice medicine by branching out as psychiatric professionals combining the empathetic nature of their profession with the influx of mental diseases. According to Aparna Kumar, *The role of psychiatric mental health nurse practitioners in improving mental and behavioral health care delivery for children and adolescents in multiple settings*, “recent data estimates that between 13-20% of children in the United States have been diagnosed with a mental, emotional, or behavioral disorder. Over the past two decades, it has also become clear that mental health disorders are on the rise among children and adolescents” (Kumar et al., 1). Seeing that mental health disease is rampant amongst the younger generations in today's day and age, it comes down to constructive input that
medical professionals must express through their expertise in didactic and high-priority interventions. Considering that the rising rate of mental health as opposed to other physical concerns is what plagues the 21st century, it is an interesting shift in public health concerns from the 1960s. Consequently, the necessary patient connection is also a task reserved for nurse practitioners in modern-day healthcare who have to address such a concern with a different type of treatment such as psychotherapy, brain stimulation therapy, and a strong support team. Seeing that mental illness was prominent but not as acknowledged during the 19th and 20th centuries, the growing concern for the effects of mental disorders has also provided a unique historical opportunity for the nurse practitioner to tackle this social health issue.

The shortcomings of a nurse practitioner come from the limited initiatives that women take in the politics of healthcare with regard to the social atmosphere. There are key organizations around the world that are expressing the necessity for people to become more involved in advocacy and policy making. Much of the backlash that nurse practitioners receive comes from unfair treatment the profession has received. This is best exemplified in Frances E. Kobrin’s *The American Midwife Controversy: A Crisis of Professionalization*. The role of the midwife was adopted from European traditions. In the reading, four different views on the conservation of midwifery emerge. One was the complete abolishment of midwives. The other view was the delayed removal of midwives when suitable substitutions have been found. Another view was the regulation and further education of the midwife to resemble the competent midwives in England. The last view is to obligate midwives and ensure they wash their hands as well as use silver nitrate as a quick fix to the rising ophthalmia in newborn infants. It was established that “an early analyst of this division in medical opinion described it as a conflict between the practical and the ideal” (Kobrin 282). Back in 19th century healthcare, social views
on the incompetent nurse were fueled by negative workers who brought shame to the profession through irresponsible behavior as well as lack of education. The importance of leadership and health policy training is something not acknowledged in contemporary times. As further outlined in RN Sue Turale and RN Wipada Kunavikutikul, *The contribution of nurses to health policy and advocacy requires leaders to provide training and mentorship* “we argue for nurses around the world to take their place at decision-making tables and to be rightfully engaged in policy, health reform and advocacy. Nurse leaders need to provide them with access to well-thought-out policy training programmes (Turale et al., 5). Seeing that nurses are held to the same “training programmes” and board licensing as other healthcare professionals, the stagnant nature when it comes to “reform and advocacy” seems highly contentious. Since most nursing work from a historical timeline has reduced their standing, it is no surprise why a more well-rounded voice is needed to upraise the duties of a nurse practitioner in contemporary healthcare.

Nursing also makes up the majority of the healthcare sector. As described in the same article “nursing is the largest component of the health workforce everywhere, but the profession has not yet realized its ‘potential to profoundly influence policy and politics on a global scale’ even though it is the moral and professional obligation of nurses to be engaged in legislation that impacts their patients” (Turale et al., 7). The inefficient political officials coupled with the lack of resources that nurses are allocated does injustice to the plethora of services that these competent nurses can provide. More importantly, the work of a nurse practitioner or a physician means no difference if the wellbeing of the patient isn’t prioritized. With a reduced quality of life, the systematic redistribution of resources is pivotal in ensuring all patients are treated equitably. Likewise, Lippincott Williams & Wilkins’, *The Nurse Practitioner Question* shows the concern of five nurses actively involved in the emergence of the nurse practitioner on the
American stage. One of the five people, Kohnke, explains that “semantics is one of the major problems. When my two partners and I went into independent practice, we got calls from medical societies and other groups to speak about this new product on the market” (Williams et al., 3). This explains that the name - nurse practitioner - is very novel and not something that requires time to get accustomed to. Similar to how any new profession experiences criticism from both the public and prominent figures in the professions, the vitality of the nurse practitioner is rooted in the all-rounded services that these practitioners can provide. The answer then becomes a social normalization of the name which removes any preconceived and restrictive notions about the competency of these practitioners. Further supported by M.S White’s, *Psychological character of the nurse practitioner*, a key feature of nurse practitioners is that a majority of them are women and “thus were are doing research on an interesting group at a significant time in women’s history … we may also gain a deeper understanding of the lives of adult women and how they are affected by social change and changing times” (White 2). Hence, the social atmosphere in which a nurse practitioner practices is not something that is set in stone; rather, it is met with criticism and there must be a constant need to defend the work that one does. With an evolving society, nurse practitioners who are predominantly women are also explaining a changing face in holistic medicine.

Therefore, the psychological and social accounts of the nurse practitioner range on a historical spectrum and can appear contentious because of the uncertainties surrounding the newly developed profession. However, the role is becoming more appropriate for the demanding results of healthcare which has an associated social and psychological growth with increasing standardization, purpose, healthcare issues, joint effort, advocacy, and more healthforce regulations in 19th, 20th and 21st century societies. As time advances, this role will approach the
final stages of development and resemble a psychosocial paradigm capable of incorporating the multifaceted aspects of healthcare as nursing has remarkably done since its inception.
Works Cited


