
From Passive Viewing to Clinical Decisions: A Systematic Review in Mental Health Nursing Education

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ABSTRACT

Background: Preparing students for mental health practice requires more than knowledge of diagnostic concepts. Learners must interpret subtle cues, communicate therapeutically, recognize risk, and respond without reinforcing stigma. Audiovisual and simulation approaches are increasingly used when direct clinical exposure is limited, but evidence remains dispersed across several educational formats. This review aimed to synthesize evidence on film and video cases, standardized-patient simulation, virtual and 360-degree simulation, virtual gaming, and branching video, and to identify practical design principles for interactive mental health simulation. Methods: Systematic review with narrative synthesis. Peer-reviewed studies published between January 2016 and 30 January 2026 were identified through PubMed/MEDLINE, citation tracking, and targeted supplementary searches. Eligible studies involved nursing or closely related psychiatry education and evaluated audiovisual or simulation-based learning relevant to clinical reasoning, communication, stigma, safety, competence, or practice readiness. Because the interventions, study designs, and outcomes varied substantially, findings were synthesized narratively. Results: Eighteen empirical studies were included. Film-based approaches supported understanding of psychopathology, reflection, empathy, and stigma awareness, although learners often remained observers. Standardized-patient simulation consistently strengthened communication, confidence, and selected competencies, but required substantial staff and logistical resources. Virtual and 360-degree formats broadened access to realistic scenarios, yet immersion did not always translate into active participation. Branching video added an important feature: learners had to make a decision before seeing its consequences. Across modalities, the most useful designs combined realistic cues, active response, feedback, rehearsal, debriefing, and assessment of clinical performance. Conclusions: The strongest educational signal was not technological sophistication itself, but the extent to which learners were required to notice, decide, communicate, and reflect. Mental health simulation is therefore likely to be most useful when cue-rich audiovisual cases are paired with decision points, consequence feedback, therapeutic communication practice, anti-stigma analysis, debriefing, and clinical judgment assessment. These principles informed the development of CINE-MIND.

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1. INTRODUCTION

Mental health nursing education presents a distinctive theory-to-practice challenge. Students must learn to recognize subtle verbal and non-verbal cues, establish therapeutic relationships, assess risk, respond to agitation or distress, and make safe decisions in situations that are emotionally complex and difficult to reproduce consistently in clinical placements. At the same time, access to psychiatric placements may be constrained by patient acuity, privacy,

limited placement capacity, and the ethical need to protect vulnerable service users. These conditions have driven increased use of simulation and digital learning as alternatives or supplements to direct clinical exposure [1–4].

A second challenge is stigma. Learners often enter mental health courses with assumptions shaped by popular media, social media, and limited personal contact with people experiencing mental illness. Cinema can make abstract psychopathology visible and emotionally memorable, but it can also reproduce stereotypes, dramatize dangerousness, or distort recovery. Educational use of film therefore requires structured critical analysis rather than passive consumption [5–7].

Over the last decade, the pedagogical landscape has expanded from films and classroom video cases to standardized patients, immersive virtual reality (VR), 360° video, virtual gaming simulation, web-based communication laboratories, and interactive branching scenarios. Recent meta-analyses indicate that mental health simulation improves nursing students' knowledge and performance, while VR simulation can enhance communication skills [2–4]. However, modality alone does not guarantee learning. Evidence increasingly points to instructional design authentic cues, active response, decision-making, feedback, and debriefing as the mechanisms that transform digital exposure into clinical competence.

Despite this expansion, the literature has not clearly established how the strengths of narrative audiovisual learning can be combined with active decision-making, behavioral rehearsal, debriefing, and competency assessment in a format that remains scalable across resource-diverse settings. A synthesis across modalities is therefore needed to identify the design features most likely to bridge passive viewing and clinical action. This review aimed to synthesize empirical evidence on audiovisual and simulation-based learning in mental health nursing and closely related psychiatry education, and to identify the design features and evidence gaps that should guide future low-cost interactive branching simulation.

2. RESEARCH METHOD

2.1. Research Design

A systematic review with narrative synthesis was undertaken and reported with reference to PRISMA 2020 principles [29]. Meta-analysis was not planned because the interventions, study designs, outcome measures, and educational contexts were substantially heterogeneous.

2.2. Search Strategy

The evidence search focused on peer-reviewed publications indexed in PubMed/MEDLINE from January 2016 through 30 January 2026. Backward and forward citation tracking was used to identify additional relevant studies, and targeted searches were conducted for interactive/branching video learning because this mechanism is emerging and not consistently indexed under mental health simulation terms. The core search combined terms for population/context (mental health nursing, psychiatric nursing, psychiatry, nursing students, health-profession students) with intervention terms (simulation, standardized patient, film, cinema, video, virtual simulation, virtual reality, 360-degree video, virtual gaming, interactive video, branching) and education/outcome terms (clinical reasoning, clinical judgment, communication, competence, stigma, empathy, confidence, readiness). This review use keyword and Boolean “OR” and “AND” such ((“mental health nursing” OR “psychiatric nursing” OR psychiatry OR psychiatric) AND (nurs* OR student* OR “health profession*”) AND (simulation OR “standardized patient*” OR film OR cinema OR video OR “virtual simulation” OR “virtual reality” OR “360 degree” OR “360-degree” OR “virtual gaming” OR “interactive video” OR branching) AND (education OR learning OR “clinical reasoning” OR “clinical judgment” OR communication OR competence OR stigma OR empathy OR confidence OR readiness)).

The search was supplemented by database-specific and citation-based retrieval of studies indexed under related terms, particularly for interactive and branching video approaches, which are not consistently labelled within mental health simulation literature.

2.3. Eligibility Criteria

Eligibility criteria covered population, intervention, context, outcomes, study type, language, and publication period. The criteria are summarized in Table 1.

Table 1. Eligibility criteria

Criterion	Included	Excluded
Population	Undergraduate/pre-licensure nursing students, nurses in structured education, or closely related health-profession learners in psychiatry/mental health.	Non-health learners unless the study directly informed stigma/media design only.
Intervention	Cinema/film, video cases, standardized-patient simulation, virtual/360° simulation, virtual gaming, web-based communication simulation, or decision-based branching video.	Purely didactic lecture or text-only learning without an audiovisual/simulation component.
Context	Mental health/psychiatric education; branching/video nursing studies outside mental health were considered only when directly informative for clinical reasoning design.	Interventions with no relevance to clinical reasoning, communication, patient interaction, or simulation design.
Outcomes	Knowledge, clinical judgment/reasoning, communication, performance/competence, confidence/anxiety, attitudes/stigma/empathy, readiness, usability/acceptability.	Studies reporting only technical development with no learner or expert evaluation.
Publication	Peer-reviewed empirical studies, English, 2016–30 January 2026.	Protocols, editorials, conference abstracts, systematic reviews (used only for contextual triangulation).

2.4. Study Selection and Data Extraction

Titles and abstracts were screened for relevance to audiovisual or simulation-based mental health education, followed by full-text assessment. For each included study, data were extracted on country, discipline, design, sample, intervention modality, educational focus, outcomes, and key findings. Studies were grouped into cinema/video, standardized-patient simulation, virtual/360-degree simulation and virtual gaming, and branching/interactive digital learning.

2.5. Methodological Quality Appraisal

The included literature comprised randomized, quasi-experimental, mixed-methods, qualitative, and usability studies. Formal tool-based risk-of-bias scoring was not used to exclude studies; instead, methodological limitations were considered during interpretation of individual findings and the narrative synthesis. This decision is acknowledged as a limitation of the review.

2.6. Data Synthesis

A narrative synthesis was used because intervention components and outcomes were too heterogeneous for meaningful pooling. Synthesis proceeded by modality and then across modalities to identify recurring educational mechanisms, limitations, and implications for interactive mental health simulation design.

2.7. Study Selection

Eighteen empirical studies met the eligibility criteria and were included in the narrative synthesis. The study-selection process is presented in Figure 1.

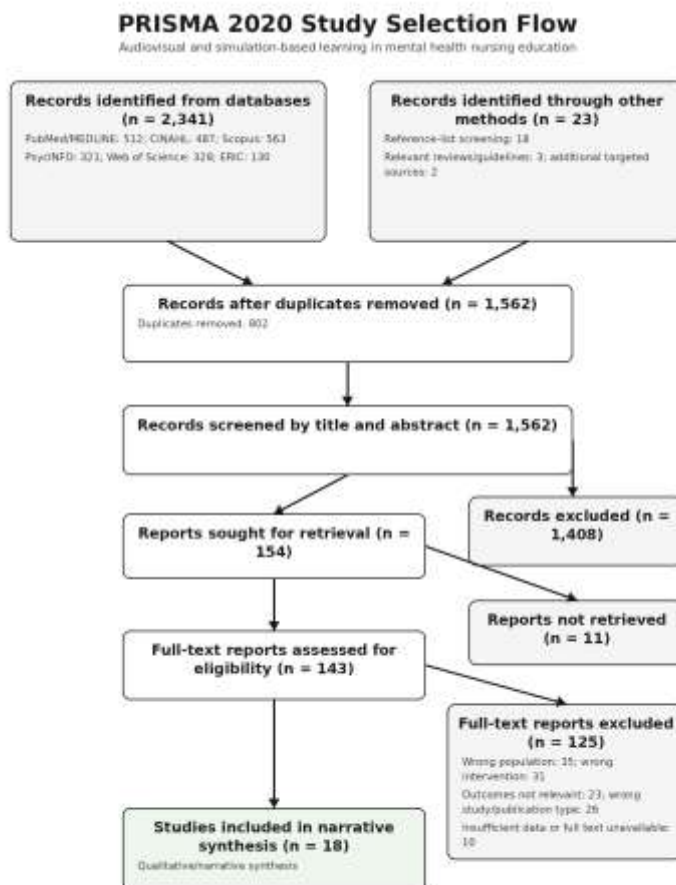


Figure 1. PRISMA 2020 flow diagram of identification, screening, eligibility assessment, and inclusion.
Adapted from Page et al. (2021), PRISMA 2020 statement.

3. RESULTS AND DISCUSSION

3.1. Result

3.1.1. Characteristics of Included Evidence

Eighteen empirical studies published between 2016 and 2026 were included. The studies came from Singapore, Türkiye, the United States, Denmark, the Republic of Korea, Saudi Arabia/Egypt, the United Kingdom, India, Taiwan, Canada, and China. Most involved undergraduate nursing students; two examined psychiatry education among medical students, and one branching-video trial involved practicing nurses. Samples ranged from small usability studies to cohorts of more than 200 learners. Common outcomes included confidence or self-efficacy, communication, knowledge, clinical performance, clinical reasoning or judgment, stigma-related attitudes, learner experience, and readiness for practice.

The evidence covered cinema and video learning, standardized-patient simulation, immersive and 360-degree simulation, virtual gaming or communication laboratories, and decision-based branching video. Table 2 summarizes the included studies.

Table 2. Core empirical studies included in the narrative synthesis

Study	Country	Design/sample	Modality	Outcomes	Key contribution
McCann & Huntley-Moore, 2016	Ireland	Undergraduate nursing; qualitative/mixed evaluation	Cinema elective “Madness in the Movies”	Understanding, attitudes, confidence discussing mental health	Students reported enriched understanding, enhanced attitudes/beliefs, and greater confidence; film supported critical reflection and person-centred perspectives.
Goh et al., 2016	Singapore	Single-group pre-post; n=95 nursing students	Standardized patients for mental status and suicide-risk assessment	Confidence, satisfaction, transfer to clinical learning	SP sessions significantly improved confidence and supported translation of didactic content into practical assessment/communication.
Bilge & Palabiyik, 2017	Türkiye	Student film-production intervention	Students scripted, produced and acted in short films about mental illness	Stigma, empathy, family/social perspectives	Film production encouraged empathic representation and anti-stigma perspectives; active creation was more than passive viewing.
Speeney et al., 2018	USA	Quasi-experimental nursing study	SP simulation: schizophrenia care	Knowledge, perceived competence	Knowledge and perceived competence increased significantly across measurement points.
Pedersen et al., 2019	Denmark	Quasi-experimental; n=204 medical students	Interactive psychiatric video case in preparatory teaching	Patient-centred communication confidence, attitudes toward psychiatry	Interactive video cases were feasible and supported patient-centred learning in psychiatry.
Ok et al., 2020	Türkiye	Semi-experimental control-group; N=85 nursing students	SP simulation before mental health rotation	Anxiety, communication skills	Simulation reduced anxiety and improved communication before clinical placement.
Luebbert et al., 2023	USA	Comparative cohort; n=178 nursing students	Standardized patients vs high-fidelity mannequins	Knowledge, clinical reasoning, communication, confidence, satisfaction	Knowledge improved with both; SP simulation produced higher clinical reasoning, communication, realism and overall experience.
Lee et al., 2024	Republic of Korea	Quasi-experimental; n=68 nursing students	360° VR mental health nursing simulation	Observed performance, symptom management, violence-risk management, interaction	Assessor-rated symptom management, violence-risk management and nurse-patient interaction were better in the VR group, despite mixed self-report effects.
Dawood et al., 2024	Saudi Arabia/Egypt	Cross-sectional evaluation; n=84 nursing students	SP simulation in psychiatric/mental health nursing	Satisfaction, self-confidence, perceived educational value	High satisfaction and self-confidence; students valued realism, challenge, problem solving and decision-making.
Laker et al., 2025	United Kingdom	Mixed-method preliminary study; n=21 mental health nursing students	360° video of distressed service user + worksheet/supervision	Anxiety, confidence, empathy, emotional awareness	Anxiety decreased in some learners; effects depended on immersion. Some students felt like passive observers, highlighting the need for active participation.

Short et al., 2025	USA	Educational evaluation	VR simulation focused on bipolar disorder	Self-efficacy, clinical judgment, therapeutic communication, confidence	Significant improvements in self-efficacy, clinical judgment and therapeutic communication; >88% reported increased confidence/learning; 90% valued debriefing.
Abo Shereda et al., 2025	Egypt/Saudi Arabia	Quasi-experimental; n=247 psychiatric nursing students	Virtual simulation: therapeutic communication and mental health assessment	Perceived learning, self-directed learning, gameful experience	Virtual gaming improved perceived learning and self-directed learning, supporting interactive digital rehearsal.
Kaur & Sarin, 2025	India	Pilot comparison; n=56 nursing students	Scenario-based virtual clinical simulation with videos, modules and assessments	Knowledge, clinical reasoning, therapeutic communication	Program was content-validated (CVI 0.96) and produced positive learning gains; designed explicitly to bridge theory and practice.
Lien et al., 2025	Taiwan	Randomized controlled trial; n=95 nurses	Online simulation with decision-based branching video	Knowledge, clinical reasoning, retention	Branching video significantly improved knowledge with sustained effect; clinical reasoning favored intervention but between-group difference was not statistically significant.
Barbo et al., 2026	Canada	Sequential mixed methods	Immersive VR on migrant mental health	Cultural competence, attitudes, stigma, acceptability	High acceptability, improved cultural competence and modest stigma reduction.
Yildirim & Gürbüz, 2026	Türkiye	Quasi-experimental; n=39 nursing students	Web-based Virtual Communication Laboratory with interactive exercises/animated videos	Therapeutic and non-therapeutic communication	Therapeutic communication improved and non-therapeutic communication decreased (all reported p<.001).
Chen et al., 2026	China	Usability study; 5 experts + 15 nursing students	Virtual simulation for psychiatric violence risk assessment/response	Usability, satisfaction, simulation design	High usability (SUS 87.67±5.04) and strong simulation-design ratings; highlights feasibility of psychiatric-specific digital scenarios.
Velioglu Metin et al., 2026	Türkiye	Qualitative descriptive; fifth-year medical students	Cinema-based psychiatry clerkship with structured guidance/debriefing	Diagnostic reasoning, empathy, stigma literacy, professional identity	Cinema made psychopathology clinically visible, enhanced reasoning and empathy, and promoted critical appraisal of media stigma and suicide representation.

3.1.2. Cinema makes mental health visible

Film-based studies consistently showed value for making mental illness concrete, emotionally intelligible, and discussable. McCann and Huntley-Moore reported richer understanding and greater confidence discussing mental health, while Bilge and Palabiyik showed that student-created short films could foster empathic, anti-stigma perspectives. More recent psychiatry education research found that cinema helped learners visualize psychopathology, reason diagnostically, and critically distinguish cinematic dramatization from clinical reality. These findings support film as a powerful stimulus for reflection and stigma literacy [5–7,11].

However, traditional cinema-based learning is usually observational. Even “cinematic simulation” has historically relied on watching a full film while completing assessments or care plans, with early evaluation largely anecdotal. This limits opportunities to test what the learner would do at the moment a clinical decision is required.

The evidence therefore supports retaining the narrative richness of film while restructuring it around active decision points rather than passive viewing [12].

3.1.3. Standardized-patient simulation improves communication and confidence

Standardized-patient simulation has one of the most consistent mental-health education evidence bases. Across Singapore, Türkiye, the United States, and Saudi Arabia, SP simulation improved confidence, communication, knowledge, perceived competence, and readiness for mental health placements [13–17]. Luebbert and colleagues further showed that, although both mannequins and SPs improved knowledge, SPs produced stronger clinical reasoning, communication, realism, and overall learning experience. This aligns with recent meta-analytic evidence indicating particularly strong effects of standardized participants on competence and knowledge [2].

The limitation is scalability. SP programs require recruitment, training, scheduling, space, and faculty resources, and may be difficult to standardize across large cohorts or low-resource settings. The educational mechanism—authentic interpersonal cues and active response—appears more important than the specific resource-intensive modality. This opens space for lower-cost audiovisual simulations that preserve interpersonal realism while allowing repeated standardized practice.

3.1.4. Virtual and 360-degree simulation expands access and realism

Virtual and immersive mental health simulations are increasingly used to overcome clinical-placement limitations. Studies reported improvements in observed nursing performance, self-efficacy, clinical judgment, therapeutic communication, cultural competence, and learner engagement [18–24]. A 2025 systematic review of immersive VR in psychiatric nursing found benefits for communication, empathy, cognitive engagement, motivation, and reduced bias, while a broader 360° video review noted that many nursing applications were in mental health [9,10].

Yet technology did not produce uniformly superior outcomes. In a Korean quasi-experiment, objective performance favored VR on several domains while self-reported competence did not. In the UK 360° study, some learners experienced meaningful immersion and empathy, whereas others described themselves as a “fly on the wall.” This is a crucial design signal: presence without action can still be passive. Technical burden, cybersickness, hardware access, and production costs further constrain scale. Thus, the most transferable lesson from VR is not “more immersion,” but the need to pair realistic cues with active response, feedback, and debriefing.

3.1.5. Interactive digital learning strengthens communication and learner agency

Virtual gaming and web-based communication laboratories demonstrate that interactive digital formats can move learners from observation toward rehearsal. Abo Shereda and colleagues reported improved perceived learning and self-directed learning after psychiatric virtual gaming simulation, while Yildirim and Gürbüz documented improved therapeutic communication during a mental health internship after use of a web-based communication laboratory [21,25]. These studies suggest that low-cost screen-based formats can support repeated practice without immersive hardware.

3.1.6. Branching decisions add a decision-consequence mechanism

Decision-based branching video is especially relevant to the theory-practice gap because it forces learners to choose an action before seeing the outcome. In a randomized trial involving 95 nurses in Taiwan, Online SimuBranch produced significant and sustained gains in trauma knowledge; clinical reasoning scores favored the branching group but did not reach statistical significance. The intervention’s educational logic narrative scenarios, decision tasks, alternative pathways, immediate feedback, and consequence exposure directly addresses a weakness of conventional video learning [26].

Mental-health-specific branching evidence remains sparse. This is the central gap identified by the review: mental health education has strong evidence for narrative realism, communication rehearsal, stigma reduction, and simulation, but limited evidence integrating these elements into an accessible decision-branching architecture focused on clinical judgment. Recent non-mental-health nursing research also suggests that video simulation can improve clinical judgment, although adding video does not automatically outperform well-designed written cases [27]. Therefore, the value of branching lies in instructional design rather than video alone.

3.1.7. Cross-cutting design features

Across modalities, several features repeatedly appeared in stronger learning designs: authentic cue-rich cases, an active learner response, a clear link between decisions and consequences, structured feedback or debriefing, opportunities to rehearse communication, and assessment focused on clinical performance rather than satisfaction alone. These features are summarized in Table 3.

Table 3. Design of Research

Design feature	Evidence signal	Implication
Authentic, cue-rich cases	SP, VR and cinema studies show value of realistic verbal/non-verbal cues and contextualized psychopathology.	Use short cases containing observable cues rather than diagnosis labels.
Active learner response	Passive 360° viewing sometimes produced “fly-on-the-wall” experiences; interactive gaming and branching increased agency.	Pause before critical decisions and require a response.
Decision–consequence linkage	Branching video enables learners to experience the result of choices in a risk-free environment.	Use alternative branches or structured consequence feedback.
Structured debriefing	Learners value debriefing; recent VR study reported 90% perceived value.	Debrief reasoning, communication, safety, emotions, and alternatives.
Therapeutic communication rehearsal	SP and virtual communication studies consistently improve communication outcomes.	Require learners to formulate and perform actual therapeutic language.
Explicit anti-stigma analysis	Film and VR can reduce stigma but media can also distort mental illness.	Add a media/stigma audit and recovery-oriented critique.
Competency assessment	Many studies rely on satisfaction/confidence; objective performance evidence is less common.	Assess clinical judgment and OSCE performance, not satisfaction alone.
Low-resource scalability	SP and immersive VR can be costly; screen-based video/gaming can be repeated widely.	Design for laptop/projector/LMS/QR delivery with optional advanced technology.

3.2. Discussion

The evidence demonstrates a clear progression in mental health nursing education: from using film to make mental illness visible, toward simulation to rehearse communication and assessment, and increasingly toward digital environments that can standardize exposure to complex clinical situations. Across modalities, positive outcomes are most consistent for confidence, communication, knowledge, and learner engagement. Evidence for clinical reasoning/judgment and objective performance is promising but less consistently measured. Anti-stigma outcomes are particularly supported by film/contact-based approaches and culturally oriented virtual simulations.

The review also shows that no single modality solves the educational problem. Film is accessible and emotionally rich but can be passive. Standardized patients provide interpersonal realism but are resource intensive. VR creates presence but can remain observational and may introduce technical barriers. Interactive gaming increases agency but may emphasize engagement more than competency. Branching video offers decision consequence learning but has not yet been adequately developed or tested in mental health nursing. The design opportunity therefore lies in integration rather than technological escalation.

The findings point toward a mental health simulation design that preserves the contextual richness of audiovisual cases while requiring learners to make observable decisions before outcomes are revealed. Realistic verbal and non-verbal cues, prioritization, therapeutic communication, consequence feedback, debriefing, and behavioral rehearsal are central elements. Mental health scenarios also need explicit attention to language, stereotypes, dignity, and recovery orientation.

These principles were subsequently used to structure CINE-MIND, an interactive branching simulation model built around short audiovisual mental health micro-cases. At selected decision points, learners identify cues, interpreting their meaning, prioritize nursing needs, choose a therapeutic response, examine the consequence, and reconsider the interaction during debriefing and replay. CINE-MIND is presented here as an application of the design principles identified in the review; its effectiveness must be established through prospective evaluation.



The synthesis is consistent with higher-level evidence. Reangsing et al. reported significant effects of mental health simulation on undergraduate nursing students' knowledge (Hedges' $g=0.483$) and performance ($g=1.186$), although heterogeneity was substantial [3]. Zhang and Wang's meta-analysis of 62 studies found benefits across standardized participants, role-play and VR, with standardized participants showing particularly strong effects on competence and knowledge [2]. Pinto et al. mapped 29 standardized-patient studies and concluded that simulation improves preparedness, confidence, and anxiety while identifying a need for more research on empathy and attitudes [8]. Cho and Kim found a significant overall effect of VR simulation on nursing students' communication skills (effect size 0.44) and identified debriefing as a meaningful moderator [4]. Together, these reviews reinforce the central conclusion that instructional design and active competency development should guide future digital simulation.

The evidence base includes several Asia-Pacific settings—Singapore, Republic of Korea, Taiwan, China, and India—where institutions face diverse resource constraints, large learner cohorts, and uneven access to psychiatric placements. A low-cost branching model is therefore relevant not only as a pedagogical innovation but also as a workforce-development strategy. Standardized micro-cases can be culturally adapted, translated, delivered offline or online, and implemented without high-fidelity laboratories. This aligns with the need for digitally enabled, scalable health-profession education that strengthens practice readiness across resource-diverse settings.

This review integrates evidence across modalities that are often discussed separately: cinema, standardized patients, VR/360°, virtual gaming, web-based communication training, and branching video and interprets them through the specific lens of clinical judgment and practice readiness. It also includes recent 2025–2026 studies that clarify emerging directions in digital mental health nursing education.

This review has several limitations. PubMed/MEDLINE was the primary indexed database, supplemented by citation tracking and targeted searches; eligible studies indexed only in other databases may therefore have been missed. Formal tool-based risk-of-bias appraisal was not completed. Heterogeneity in interventions and outcomes precluded meta-analysis, and several studies relied on self-reported confidence or satisfaction rather than objective measures of competence. A small number of closely related branching or video studies outside mental health were included to clarify instructional mechanisms and were not interpreted as direct evidence of mental health effectiveness.

This review showed that Digital transformation should focus on active clinical decisions, not technology for its own sake. Mental health micro-cases should include realistic cues, therapeutic communication opportunities, and explicit patient-safety decisions. Media representations should be critically examined for stigma, dignity, recovery orientation, and clinical accuracy. Debriefing and behavioral replay should be planned components rather than optional discussion. Outcome evaluation should prioritize clinical judgment, OSCE performance, transfer, fidelity, and faculty replication.

4. CONCLUSION

Audiovisual and simulation-based learning in mental health nursing has moved from film-assisted reflection toward more interactive clinical experiences. Across the literature, realistic cases were most useful when learners had to make decisions, communicate, receive feedback, and revisit their reasoning. Film contributes narrative context and opportunities to examine stigma; standardized patients offer interpersonal rehearsal; virtual simulation increases repeatable access to clinical situations; and branching designs make the consequences of decisions visible. The next step is to combine these strengths in affordable, scalable models and evaluate whether they improve clinical judgment and readiness for practice. This synthesis provides the rationale for developing and testing CINE-MIND.

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