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ORIGINAL RESEARCH

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"Sorry to call."—a narrative approach to overcoming help-seeking barriers among suicidal men

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Abstract

Background: Suicide rates among men remain disproportionately high, in part due to traditional masculine norms that discourage emotional expression and help-seeking. Narrative-based interventions may offer a promising strategy to address these gendered barriers, notably by fostering identification through shared lived experiences. This study aimed to co-design, disseminate, and evaluate lived-experience stories to promote use of the French national suicide prevention helpline (3114). **Methods**: We conducted a five-phase action-research protocol grounded in co-design principles: (1) semi-structured interviews with men who self-reported a positive experience with 3114 (n = 5); (2) collaborative rewriting and validation of their stories; (3) online dissemination via the 3114 website and social media; (4) follow-up interviews with new male readers (n = 7) to explore perceived impact; and (5) narrative optimization. We collected web analytics and qualitative data, which were thematically analyzed to examine the influence of masculine norms on help-seeking and the impact of the narratives. **Results**: The co-design process enabled the creation of ethically sound, adaptable prevention materials grounded in lived experience. All participants highlighted the negative impact of hegemonic masculine norms on help-seeking, citing fears of being seen as illegitimate, feelings of shame, and the prioritization of others' needs over their own. Male readers strongly identified with the narrators, particularly through shared experiences tied to masculinity. This identification fostered a greater sense of legitimacy, self-efficacy, and readiness to seek help. Notably, some participants reported contacting 3114 after reading the stories. **Conclusions**: Narrative interventions can reduce gendered barriers to help-seeking among suicidal men by presenting alternative masculine narratives that normalize vulnerability and reframe help-seeking as a legitimate and relatable response to distress. This gender-sensitive approach offers a scalable model for integrating lived experience into suicide prevention strategies. Future research should assess long-term effects and broader applicability.

Keywords

Suicide prevention; Help-seeking; Hegemonic masculinity; Narrative-based intervention; Digital public health; Lived experience; Crisis helpline; Gendered health behaviours; Men's health

1. Introduction

Globally, around 727,000 people die by suicide each year—equivalent to more than one death every minute [1]. In most countries, the suicide rate among men exceeds 10 per 100,000 and is roughly twice as high as that of women [2]. While the exact causes of this defining feature of suicide epidemiology remain unclear, several contributing factors have been identified. These include a higher prevalence of undiagnosed mental health conditions [3], and more frequent alcohol and substance abuse [4]. However, the degree of gender disparity significantly varies across countries, with patterns often corresponding to levels of development (*e.g.*, higher male-to-female suicide ratios in Western countries) or political history (*e.g.*, similar trends in former Union of Soviet Socialist Republics (USSR) countries) [2]. This persistent observation suggests deeper social and cultural determinants [5], such as culturally embedded masculine scripts [6] and type of masculine socialization [7].

Socialization patterns are deeply shaped by implicit representations of gender expressions [8]. In many countries, particularly in the Western world [8], these gender structures are organized around a dominant model of masculinity, which Connell and Messerschmidt describe as "hegemonic masculinities" [9]. In this framework, masculinity is understood as a social construct that encompasses multiple gender expressions,

all of which are subordinated to a dominant, stereotypical, and early-learned model of "how to be a real man" [10]. Several authors have proposed characteristics to define this model. Connell, for instance, identifies traits such as strength, authority, and rationality as hallmarks of hegemonic masculinity [11].

In the same vein, Jansz highlights four key attributes of the Western traditional male role: (1) stoicism, or the pressure to suppress one's suffering, (2) autonomy, or the expectation to solve problems independently, (3) achievement, or the drive to succeed in all endeavours, and (4) aggressiveness, or the tendency to act aggressively when necessary [12].

Importantly, adherence to hegemonic masculinity traits has been associated to an increased risk of mental health issues, including psychological distress and depression [13–15], harmful behaviours [5], as well as feelings of shame and low self-esteem [14]. Conversely, struggling to conform to these masculine ideals can also lead to shame, isolation, and distress [16, 17]. Whether one adheres to or strives to meet these norms, hegemonic masculinity creates barriers to accessing care by discouraging emotional expression [5] and reinforcing reluctance to seek support [14, 16, 18]. According to the "double penalty theory", this results in a twofold burden: not only do vulnerable men face sociocultural obstacles to receiving appropriate care, but they also endure additional shame and a sense of failure [19], as seeking help is often perceived as a sign of "weakness" [20]. This vicious cycle tends to exacerbate men's vulnerability, particularly increasing their risk of suicidal behaviours [14]. This pattern is consistent with a recent systematic review of 47 studies, which found that traditional masculinity norms both intensify men's psychological distress and inhibit help-seeking across settings [21]. A separate systematic review focusing on male suicide reports that hegemonic masculinity is directly implicated in suicidal thoughts, attempts, and deaths in men, and stresses the need for gender- and intersectionality-informed prevention [22]. Recent person-centered work similarly identifies a "Stoics" subgroup of men—defined by restrictive emotionality, self-reliance, and risky behaviour—who show 2.32× higher odds of a lifetime suicide attempt [23].

In this context, crisis helplines represent a particularly valuable resource: by offering privacy, accessibility, and greater control over the help-seeking process, they can help men circumvent barriers associated with masculine norms [5]. However, effectively promoting suicide prevention helplines for men presents a complex challenge. According to Keohane and Richardson, such targeted communication campaigns must account for the typical barriers and motivators that influence men's willingness to seek and accept help, incorporating masculine linguistic and visual codes [19]. While these tailored health interventions have been proven effective in increasing men's engagement with health services [24], they also implicitly reinforce masculine stereotypes in collective perceptions, paradoxically sustaining hegemonic masculinity.

Incorporating the voices of those directly affected may help resolve this paradox. Personal experiences offer valuable insights into the complex interplay of individual, contextual, systemic, and sociocultural factors that shape subjective realities. Personal narratives from relatable individuals can strongly influence behavioural determinants [25–27].

While powerful, testimonies are not without risk though. They expose individuals who share their stories [28] and may lead to narratives that do not align precisely with specific public health objectives. The narrative approach offers a productive balance. It helps the narrator structure their experiences to provide coherence and meaning, while also allowing the reader to reinterpret the story, fostering personal insight and moral reflection [29]. This approach introduces greater flexibility, making it easier to align the narrative with prevention goals. In particular, storytelling supports the creation of positive role models, which, according to Bandura's social learning theory, can foster identification and motivate protective imitation [30]. Over the past decades, modelling principles have demonstrated effectiveness in enhancing self-efficacy, skills, and behavioural intentions across a range of domains [31, 32].

In this action-research study, we aimed to: (1) develop and disseminate role-model narratives based on real-life stories to encourage men to call 3114, the French national suicide prevention helpline; and (2) to explore how these narratives might shape men's representations, sense of legitimacy, and perceived ability to seek help through this service.

2. Materials and methods

To design the prevention narratives and assess their potential effect, we used a Cyclical Evaluation Process [33, 34]. Originating from the field of digital public health, this mixed-methods approach consists of four iterative steps that ensure the combination of multiple data sources, perspectives, and analytical approaches. A central component of this process is co-design—defined as the collaborative development of interventions by integrating the perspectives of both experts and end-users—has proven particularly valuable in public and mental health promotion. Co-design ensure that interventions are not only evidence-informed but also aligned with lived experience, thereby enhancing their acceptability, contextual relevance, and impact. Within this framework, digital mental health refers to the use of online platforms, social media, and other digital tools to support mental health care and suicide prevention; in our study, it provided both the medium (3114 website and social media) and the methodological context for testing narrative-based interventions.

This protocol was approved by the Research Ethics Committee of Université Paris-Cité on 04 July 2023 (04 July 2023, No. IRB: 00012023-77).

2.1 Step 1. development

2.1.1 Participants and procedure

Participants for the story collection phase were recruited through two main channels: (1) a banner posted on the 3114 website and its social media platforms, inviting individuals to share their experiences with the helpline; and (2) 3114 operators, who introduced the study protocol to eligible callers using a standardized script.

Inclusion criteria were: (1) self-identifying as man; (2) having been personally affected by suicidal thoughts; (3) being over 35 years of age; (4) having personally perceived their experience with the 3114 helpline as positive; and (5) pro-

viding informed consent to participate in the study. Since the Papageno effect emphasizes the importance of sharing positive stories [35], and the behavior change principle of Modelling states that for narratives to be effective, narrators should portray a progression from initial struggle to eventual success in executing the target behavior, we chose to retain participants who reported negative experiences in their help-seeking process, to illustrate that and how such obstacles can be overcome. experiences in their help-seeking process, to illustrate that such obstacles can be overcome. The age criterion was selected to reflect the epidemiology of suicide, which disproportionately affects middle-aged men [2]. Participants did not receive any financial compensation for their participation.

Participants were excluded if they could not provide informed consent (*e.g.*, cognitive impairment, restrictive guardianship/curatorship, or inability to understand the study), did not have sufficient proficiency in French to take part in the interview and validate the narrative, or were in an acute suicidal crisis at the time of contact.

2.1.2 Interviews

Informed consent was obtained by the investigator (MM) before participation. Interviews were then conducted at the participant's home, in the research laboratory, or via videoconference, according to participant preference.

Each semi-structured interview began with participants being invited to share their personal stories. The interview guide was informed by role-model theory, which identifies key conditions for effective modelling (see **Supplementary material 1**). For instance, the role model should be a "coping model" rather than a "mastery model" [30], meaning the individual initially struggles with a challenge but ultimately overcomes it. Interviews were audio-recorded and fully transcribed.

2.1.3 Narrative writing

Based on the interview transcripts, a transdisciplinary research team crafted first-person narratives of the men's stories, emphasizing the steps they took to contact the 3114 helpline. In line with modelling principles, particular attention was paid to the skills and self-efficacy beliefs expressed by participants regarding their help-seeking behaviour. Adopting a narrative approach, the team also focused on linguistic elements, such as syntactic structures, lexical choices, and forms of enunciation [36]. While staying true to initial participants' testimonies, the goal was to help readers connect with the narrator, imagine themselves in his position and, ultimately, enhance their skills and boost their confidence in their ability to call 3114. For the purpose of dissemination, all participants' first names were changed to preserve anonymity.

To ensure authenticity, narratives were not over-positively represented: difficulties and ambivalences described by participants were preserved in the texts. Each narrative was then discussed by phone with the corresponding participant, who had previously received the transcript upon request. Participants asked only for minor modifications, which were addressed immediately, and brief notes were recorded in a fieldwork diary. The rewritten texts were also reviewed collectively by the research team to maintain both fidelity and ethical integrity.

2.2 Step 2. interaction analysis

After receiving participants' final approval, the narratives were visually designed and published as part of a one-month targeted communication campaign on the 3114 website and social media channels (Instagram, X, Facebook, and LinkedIn). We utilized built-in monitoring tools to analyse webpage visits and unique visitors, number of impressions (views) and engagement (comments, likes, and shares) on the posts across each social media platform.

2.3 Step 3. end-user perspectives analysis

2.3.1 Participants and procedure

We recruited further men to explore the potential impact of the narratives through a recruitment campaign on the 3114 website, social media, and operators.

Inclusion criteria were: (1) self-identifying as man, (2) being affected by suicidal thoughts, (3) being over 18 years old, (4) having personally perceived their experience with the 3114 helpline as positive, and (5) agreeing to participate in the project. Participants did not receive any financial compensation for their participation.

Participants were excluded if they could not provide informed consent (*e.g.*, cognitive impairment, restrictive guardianship/curatorship, or inability to understand the study), did not have sufficient proficiency in French to take part in the interview and validate the narrative, or were in an acute suicidal crisis at the time of contact.

2.3.2 Interviews

The interview, conducted by MM, took place via videoconference. Using the think-aloud method, participants browsed the 3114 webpage and verbalized their thoughts while reading one or several narratives. This approach offers direct insight into cognitive processes, though it may miss non-verbal reasoning [37–39]. If silence exceeded 10 seconds, the prompt "Please think aloud" was given.

Participants then engaged in a semi-structured interview. The investigator asked questions about the participants' observations and comments made during the think-aloud portion. Additional in-depth questions focused on the target behaviour and its determinants, such as whether the participant identified with the individuals described in the narratives, and whether this identification influenced their behavioural intentions, self-efficacy, or skills. To ensure participants' safety, they were reminded that they could withdraw from the interview at any time. Additionally, participants could be recontacted within three days if any signs of distress emerged. Interviews were audio-recorded and fully transcribed. Thematic analysis was conducted manually and inductively. MM (sociologist) coded transcripts into themes with an analytic memo; LR (psychiatrist) prepared participant-level summaries to preserve individual perspectives. Materials were provided to NP (communication specialist in suicide prevention) for narrative rewriting, and the rewritten testimonies were then collectively reviewed and refined by the team.

2.4 Step 4. optimization

The optimization process focused on refining the structure and tone of the narratives to enhance their clarity, coherence, emotional impact, and accessibility. This refinement was guided by two key inputs: (a) thematic insights drawn from interviews with end users; and (b) a clinical interpretation by a psychiatrist (LR). Based on these inputs, a communication specialist reworked the initial texts into an oral style. The narratives were subsequently recorded by professional actors, who were directed to convey each story with realism and warmth.

3. Results

3.1 Story collection

We conducted five interviews between 11 and 21 December 2023. The characteristics of the participants and interviews are provided Table 1. Participants' narratives supported the hypothesis that hegemonic masculine scripts exert pressure that complicates help-seeking behaviours in distressed men. In particular, the injunction to stoicism repeatedly emerged as a significant barrier. As Pierre expressed: "*You're a man, you're supposed to endure it, you have broad shoulders.*". Several participants also illustrated the double penalty theory, emphasizing both the normative pressure on men to demonstrate self-sufficiency and the emotional distress stemming from their difficulties in meeting these expectations. Strikingly, Younes employed legal terminology such as "not allowed" to describe the social repression of behaviours deemed unacceptable for men and underscored the exclusion faced by those who deviate: "*It's really hard being a man. Men don't talk about these issues among themselves—we're not allowed… (literally 'on n'a pas le droit', a phrase in French that carries a legal connotation of prohibition) if you start talking about mental health problems, you get pushed out.*".

As expected, telephone-based assistance was perceived as a way to circumvent the stereotype of the man who must "*tough it out.*". Jonathan noted: "*Even if I cry, the person doesn't know what I look like, so if we meet on the street…*". However, calling to the 3114 still confronted participants with barriers in relation male socialization. Participants used different strategies to overcome their reluctance. Benjamin recounted his journey to deconstruct the stereotype of the man as strong, assertive, and rational: "*I realized I had a bad view of unhappy people. I always thought I was strong, rational… but you must accept that you're not just strong and rational.*". Karim likewise departed from the traditional model: "*You can be sentimental… even if you're two meters tall and 150 kilos. It doesn't mean you can't cry.*". Jonathan reframed the notion of strength, reversing its normative value and reapplying it to help-seeking behaviours, thereby subverting dominant masculine ideals: "*You really do need to be strong to call. You need to be strong to bare yourself, in a sense, to someone who doesn't even know you.*".

Interestingly, traditional masculine scripts reasserted themselves in participants after their first call to the 3114 helpline. For many participants, the initial call was viewed as a legitimate way to enhance their coping capacities, whereas any subsequent call felt less acceptable or even illegitimate. As Younes explained: "Their narratives suggest that calling the helpline was viewed as a mean to enhance their coping capacities, while any subsequent calls became illegitimate. Two participants mentioned an altruistic hesitation to call again the 3114. Younes said: "*I didn't hesitate the first time, but I did the next times. I thought someone might be in worse shape or about to act, so I didn't want to flood the network.*". Benjamin shared a similar concern: "*I don't want to take anyone's place, now that I can call a psychiatrist, my doctor, or even my mother-in-law someday. At least we'd have achieved that.*". At the same time, this reluctance did not translate into passivity: participants felt empowered to seek help from other sources, which can be understood both as an altruistic consideration for others who might need the helpline more urgently and as a relaxation of the pressure imposed by traditional masculine models.

3.2 Interactions with the narratives

We created five narratives as short visual vignettes accompanied by a link to the full testimonial (see **Supplementary material 2**). We published them monthly between 15 April and 27 May 2024.

The stories published on the 3114 website received a total of 2264 visits. Each story averaged 213 views, with visitors spending from 1 minute to 1 minute and 40 seconds per page. During the same period, the stories featured on 3114's social media channels generated 49,782 impressions and 6902 interactions, including 229 shares or reposts. The detail of impressions by story and social media platform is provided Table 2.

3.3 End-user perspectives

Consistently with qualitative research standards [40] data saturation was considered reached after seven interviews, as no new themes emerged from the last two transcripts (see Table 3 for participant characteristics). Ten candidates were not in-

TABLE 1. Characteristics of participants and interview details for narrative collection (step 1).

Participant	Age	Occupation	Interview mode	Interview duration (min)
Pierre	51	Police officer on sick leave	In-person (home)	25
Benjamin	45	Farmer	In-person (home)	60
Younes	35	Unemployed	Videoconference	37
Karim	45	Mechanic	In-person (home)	27
Jonathan	38	Research engineer	Videoconference	50

TABLE 2. Number of impressions and interactions per post and social medial platform.

	Instagram	X	Facebook	LinkedIn	Total
Post 1: launch of the campaign					
Impressions	2214	220	1339	12,082	15,855
Interactions	179	14	174	586	953
Post 2: Younes' story					
Impressions	2654	723	1599	4389	9365
Interactions	250	54	164	1295	1763
Post 3: Karim's story					
Impressions	1623	2024	1051	1681	6379
Interactions	154	162	72	432	820
Post 4: Pierre's story					
Impressions	1886	1022	909	4630	8447
Interactions	177	101	81	1552	1911
Post 5: Jonathan's story					
Impressions	1092	440	803	1695	4030
Interactions	92	50	62	336	540
Post 6: Benjamin's story					
Impressions	1286	456	1286	2678	5706
Interactions	118	36	114	647	915

TABLE 3. Characteristics of participants and interview details for the collection of end-of-users perspective (step 4).

Participant	Age	Interview mode	Interview duration (min)
P01	45	Videoconference	60
P02	22	Videoconference	27
P03	26	Videoconference	33
P04	23	Videoconference	49
P05	35	Videoconference	61
P06	49	Videoconference	74
P07	42	Videoconference	50

cluded in the study: six did not meet the inclusion criteria, and four did not follow up. Interviews were conducted via videoconference between 25 June and 24 October 2024. Most participants commented on two stories. The most frequently discussed were Jonathan's and Karim's (five times each), while Pierre's story was the least discussed (only once). The interviews lasted an average of 54 minutes, with durations ranging from 27 to 75 minutes.

Eight main themes emerged from the analysis (see Table 4 for an overview of themes and codes). The first theme that emerged from the transcripts was a strong sense of identification that participants reported feeling toward the narrators. In several instances, this identification was expressed spontaneously, even before any targeted questions were asked. As one participant explained, "*I'm going to choose the last testimony by Jonathan because I relate to the refusal of emotions*" (P07). This identification often stemmed from a perceived experiential similarity with the narrators. One interviewee remarked, "*He had a physical symptom, and that was exactly what I was going through*." (P01). In some cases, the sense of similarity was so pronounced that it appeared to blur the line between self and other. As one participant put it, "*Where he said he might have a high or very high intellectual potential… that was me, exactly*" (P01). For most participants, this identification was closely linked to a strong sense of empathy toward the narrators. The perceived similarity triggered the affective dimension of empathy, or emotional resonance. As P01 described: "*There was this little sentence at the end that I recognized in myself… that was quite touching, and yeah, it made me feel close to that guy.*". Another participant highlighted the cognitive dimension of empathy—an understanding of the narrator's thoughts, motivations, and values—stating: "*I can relate to the fact that suffering leads you to care about others who suffer… I get what he means*" (P04).

The second theme that we identified related to participants' altruistic concern for others. P04 expressed worry about a narrator who had already attempted suicide: "*He mentioned a prior suicide attempt and promised not to do it again. That alarms me because it's an additional risk factor*". This altruistic concern for others is coupled with a tendency to downplay

TABLE 4. Themes and codes developed from end-users' interviews.

Theme	Code	Illustrative quotes
Identification with narrators		
	Spontaneous identification	"I'm going to choose the last testimony by Jonathan because I relate to the refusal of emotions" (P07)
	Experiential similarity	"He had a physical symptom, and that was exactly what I was going through" (P01)
	Blurring self/other	"Where he said he might have a high or very high intellectual potential… that was me, exactly" (P01)
Empathy toward narrators		
	Emotional resonance (affective dimension)	"There was this little sentence at the end that I recognized in myself… it made me feel close to that guy" (P01)
	Cognitive empathy	"I can relate to the fact that suffering leads you to care about others who suffer… I get what he means" (P04)
Altruistic concern for others		
	Worry about others' risk	"He mentioned a prior suicide attempt… That alarms me because it's an additional risk factor" (P04)
	Downplaying own distress	"Other people have worse problems; I don't want to clog up the line" (P07)
	Doubts about being "serious enough"	"There's this sense of not being 'bad enough' to justify calling" (P04)
Fear of illegitimacy		
	Fear of being a burden	"Taking someone else's place" (P05)
	Apologizing for calling	"The first thing I say is, 'Sorry to bother you'" (P05)
	Help-seeking as a moment in life, not permanent	Asking for help is episodic, not constant
Burden of gender stereotypes		
	Pressure to conform	"I felt I no longer fit the confident male stereotype" (P03)
	Prohibition of weakness	"We're not allowed to be unwell. We feel the weight of that prohibition" (P05)
	Double penalty	"It's awful… it makes you feel like a loser. So basically, it's a double penalty" (P07)
Reinforcement of self-efficacy		
	Increased willingness to call	"It strengthens the feeling—or the willingness—to call if needed" (P02)
	Narratives prompted action	"I read those stories, and then I called" (P01)
Normalization and reassurance		
	Validation of help-seeking	"It makes you want to call too… it's especially reassuring for people who are still unsure" (P03)
Practical understanding of calling 3114		
	Clarity of steps	"The steps are simple: you call… there might be a little wait" (P02)
	Realistic expectations (waiting time)	"In every story, there's a moment when things go wrong, and then—bam!—they call 3114" (P06)

their own distress, ultimately creating a barrier to help-seeking: "*Other people have worse problems; I don't want to clog up the line*" (P07).

A closely related theme was the fear of illegitimacy, which emerged as a central barrier to help-seeking. Many participants expressed doubts about whether their suffering was "serious enough" to warrant support and voiced a fear of being a burden. P04 noted, "*He mentioned calling back twice and having a thought for 'people who might need it more' than he did, so he didn't want to overwhelm the phone lines. That also held me back at first before calling 3114, because there's this sense of not being 'bad enough' to justify calling*". P05 echoed this concern about "taking someone else's place": "*He basically says he was apologizing for calling. When I dial emergency*

services, the first thing I say is, 'Sorry to bother you'".

The fourth theme that emerged from the interviews was the pain associated with gender stereotypes. Participants reflected on the emotional burden these norms impose. P03 remarked, "*He said, 'I felt I no longer fit the confident male stereotype.' That's exactly it*", highlighting the pressure to conform to rigid masculine ideals. P05 added, "*We're not allowed to be unwell. We feel the weight of that prohibition*". The idea of a double penalty—experiencing distress and then feeling shame for it—was spontaneously raised by one participant: "*It's awful, you know, […] it makes you feel like a loser. So basically, it's a double penalty: you're not doing well, and then you judge yourself for not doing well and for not being like everyone else*" (P07).

All participants reported that reading the narratives reinforced their sense of self-efficacy, increased their confidence in help-seeking, and improved their practical understanding of how to call the 3114 helpline. As P02 put it, "*It strengthens the feeling—or the willingness—to call if needed. I think that's where it really works*.". This enhanced self-efficacy was not merely theoretical: several participants explicitly stated that the stories played a direct role in their decision to reach out. As P01 recalled, "*I read those stories, and then I called*.".

The narratives also helped normalize and validate the act of seeking help, countering doubts or hesitations. For P03, "*When you see that it helped someone in the story, it makes you want to call too… it's especially reassuring for people who are still unsure*.". Similarly, P02 emphasized how the stories maintained their trust in the service: "*I wouldn't say it makes you want to call, because that's not the right word—it's not like, 'Cool, let's call 3114!' But it definitely helps keep the confidence you already have in calling*.".

In addition to emotional impact, the stories improved participants' concrete understanding of how to proceed. Several commented on the clarity and realism conveyed in the narratives. P02 noted: "*The steps are simple: you call. And it's clearly stated in one story that there might be a little wait. That's normal—unfortunately, we're not alone, and sometimes there's a queue*.". P06 echoed this view: "*In every story, there's a moment when things go wrong, and then—bam!—they call 3114. Even for me, now, I think: if things really go bad, it's just four digits to dial*.".

Together, these insights suggest that exposure to lived-experience narratives can not only inspire identification but also reduce ambiguity and lower psychological barriers to help-seeking—a key goal in suicide prevention.

3.4 Phase 5. optimization

The five digitally enhanced audio narratives were published on the 3114 website.

4. Discussion

This study explored the potential of narrative-based communication to encourage help-seeking—particularly through the French national helpline—among men experiencing suicidal crises. Our qualitative findings support the hypothesis that hegemonic masculinity traits hinder the help-seeking process by generating a sense of illegitimacy and shame compounded by a tendency to prioritize others' needs over their own. However, we found that the narratives we created, which reached a broad audience, elicited strong identification and empathy among interviewees, precisely in relation to these masculine traits. This connection appeared to facilitate a kind of "conjuration" of those same traits, fostering greater confidence, a sense of self-efficacy, and, in some cases, prompting calls to the helpline.

Our initiative aligns with an emerging trend in the literature that highlights the importance of a gendered sensitive approach to suicide prevention, recognizing the specific determinants of suicidal behaviours in men [41, 42]. Suicide-related stigma itself is linked to poorer mental health, higher suicide risk, and reduced help-seeking, which reinforces this barrier [43]. Within this perspective, several suicide prevention campaigns targeting men have shown promising results [44, 45]. For example, the Centre for Suicide Prevention in Canada has implemented a program designed by men for men, grounded in peer-to-peer support and a communication strategy that includes various male personas representing diverse social and cultural backgrounds. Similarly, our campaign eschewed stereotypical representations of masculinity. Instead, it presented diverse and experientially-based male narratives, providing alternative scripts to hegemonic masculinity. In these alternative masculine cultures [44] vulnerability is normalized and help-seeking is reframed as a form of agency rather than failure, which might be a protective factor regarding the suicidal process [46].

Interestingly, our findings also echo the growing body of literature on the Papageno effect, which suggests that exposure to stories of individuals who have successfully navigated a suicidal crisis can have a protective influence [35]. In line with Bandura's social learning theory [30], this effect is believed to be mediated by identification—where individuals are more likely to adopt modelled behaviours when they perceive the model as similar to themselves [47]. Notably, the Papageno effect has been demonstrated to be more potent when the storyteller shares key demographic or social characteristics with the audience, such as age and gender [48]—a phenomenon referred to as "horizontal identification". In our study, the effect of the stories may have been especially pronounced due to perceived male-to-male similarity.

Media campaigns and digital interventions specifically designed for men report improved help-seeking intentions and high perceived usefulness when they offer authentic male voices, concise guidance, and direct signposting to support, although effects remain uneven across formats [49, 50]. Similarly, a brief tailored digital message that directly addressed self-reported barriers to calling a suicide crisis line increased men's reported likelihood of contacting the line, even if it did not always trigger an immediate call [51]. Similarly, an online suicide-prevention campaign developed specifically for men was associated with a small increase in help-seeking intention and greater openness to talk about emotions after exposure [45]. One of the key strengths of our research-action lies in the original method we developed which was grounded in co-design principles. To create our campaign, we integrated this co-construction approach with the narrative approach. Instead of relying

on raw testimonials—which can be unpredictable in their framing and ambiguous in their interpretation—we refined the narrative material through a multi-perspective process involving those who provided them. This process aligned the narratives with our prevention objectives, while ensuring narrative fidelity and, ethical integrity. Consequently, it resulted in communication material that was both personally meaningful and publicly actionable, effectively enhancing the promotion of the 3114 helpline.

This study is subject to several limitations. The participant pool was relatively small, and those involved had already shown a propensity to reflect on and share their experiences. Consequently, the findings may not be generalizable to men who remain disengaged from support services, including those who do not actively seek information or consider help-seeking as a viable option. The number of interviews conducted to analyze men's representations of personal stories is limited. However, qualitative research prioritizes thematic depth over representativeness. In our study, seven interviews were sufficient to reach data saturation, a traditional criterion indicating that adequate insights had been obtained. However, it is to be mentioned that one of the narratives was discussed by only a single participant, which may have reduced the richness of feedback for that particular case. Furthermore, the evaluation was centered on perceived impact and self-reported intentions rather than observable behavioural outcomes, leaving the effect of peer-to-peer narratives yet to be empirically validated.

This study also highlighted challenges related to the narrative model and the co-design method. First, recruiting and interviewing a vulnerable population required time and careful ethical attention. Second, adapting participants' testimonies for public health communication required making them clear, concise, and accessible while preserving the complexity and authenticity of lived experience.

5. Conclusions

Narrative-based interventions that are carefully crafted and ethically implemented have the potential to foster personal identification, challenge gendered barriers to help-seeking, and contribute meaningfully to suicide prevention efforts. By reframing vulnerability as a legitimate and relatable experience, co-designed stories can empower men to engage more confidently with crisis and mental health services. This approach aligns with contemporary understandings of masculinities and health, offering a promising path toward more inclusive and gender-sensitive models of prevention. Future research should explore how these interventions can be scaled, adapted for diverse populations, and embedded within comprehensive, multi-modal public health strategies.

AVAILABILITY OF DATA AND MATERIALS

The datasets generated and analyzed during the current study are not publicly available due to the sensitive nature of the content and the potential risk of identifying participants. Participants did not consent to the public sharing of their full transcripts. However, anonymized excerpts relevant to the findings are included in the article, and further information may be made available from the corresponding author on reasonable request and subject to ethical approval.

AUTHOR CONTRIBUTIONS

MM, GM and CEN—designed the research study. MM, GM, LR, TD, NP and CEN—performed the research. MM and TD—analyzed the data. MM and CEN—wrote the manuscript. All authors contributed to editorial changes in the manuscript. All authors read and approved the final manuscript.

ETHICS APPROVAL AND CONSENT TO PARTICIPATE

This study was conducted in accordance with the principles outlined in the Declaration of Helsinki. All participants provided informed consent prior to their inclusion in the study. This protocol was approved by the Research Ethics Committee of Université Paris-Cité on 04 July 2023 (No. IRB: 00012023-77).

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CONFLICT OF INTEREST

The authors declare no conflict of interest.

SUPPLEMENTARY MATERIAL

Supplementary material associated with this article can be found, in the online version, at https://oss.jomh.org/files/article/201711711942913228/attachment/Supplementary%20material.zip.

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