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RESEARCH ARTICLE

Incels and psychotherapy: Experiences, attitudes, and resistance to mental-health interventions

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Abstract
Objective: Men are more reluctant than women to engage with psychotherapy. Incels—an online community of involuntary celibates—have been identified as needing mental health intervention. Despite high rates of depression, suicidality, and social isolation, little is known about their therapy experiences or attitudes.
Methods: We collected 100 psychotherapy discussion threads from incels.is, the largest incel forum. Inductive thematic analysis identified community attitudes toward psychotherapy. We also coded the experiences of 89 users who reported attending therapy, quantitatively assessing therapist gender, motivation, and satisfaction.
Results: Among incels reporting therapy experiences, 70.8% reported negative outcomes and 7.9% reported satisfaction. None of those forced into therapy (25.8%) reported positive outcomes. Thematic analysis revealed barriers to engagement: (1) "blackpill" ideology attributing sexual/romantic deprivation to immutable factors; (2) conspiracy theories framing therapy as designed to sedate and control; (3) view of therapy as female-biased and hostile to men; (4) practical concerns including cost, privacy, and hospitalization.
Conclusions: Incels present intervention challenges due to their fatalistic worldview, institutional distrust, and extreme misogyny. Findings suggest potential benefits of male therapists and clear therapeutic goals that acknowledge but do not promise to resolve romantic concerns.

Keywords: involuntary celibates; psychotherapy; masculinity; mental health; therapy resistance; online communities

Clinical or methodological significance of this article: This mixed methods study is the first to thoroughly document incel attitudes towards psychotherapy as well as their reported therapy experiences (i.e., motivation, satisfaction). Our analyses reveal widespread dissatisfaction and hostility towards therapy, identifying several barriers to intervention. These emotional and ideological hurdles should be taken into account if successful therapy is to be conducted with incel patients. We conclude by discussing suggestions to improve incel therapy engagement.

Objective

Men tend to be more reluctant than women to engage with psychotherapy and other mental health services (Addis & Mahalik, 2003; Shepherd et al., 2023). Most explanations argue that current Western cultural ideals of masculinity, with their emphasis on self-reliance and emotional control, hinder men's attempt at seeking help (Addis & Mahalik, 2003; Englar-Carlson et al., 2010; Seidler et al., 2016). Others point out the lack of explicit prevention and outreach programs targeting men's mental health issues, or the lack of male

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psychotherapists (Shepherd et al., 2023). This issue is all the more pressing that male mental health is showing signs of worsening among younger generations (Haidt, 2024).

One group of young men in particular has been repeatedly singled out for its need of mental health intervention: the incel community (Broyd et al., 2023; Costello et al., 2022, 2025; Hunter et al., 2024; Maxwell et al., 2020; Sparks et al., 2022; Van Brunt & Taylor, 2020). This online-based global community of involuntary celibate men has grown in popularity over the past decade (Ribeiro et al., 2021). It has received a lot of academic and media attention for its potential role in radicalizing young mass killers in Europe and North America (for a review of incel-related attacks, see Hoffman et al., 2020; but see Costello & Buss, 2023). It started as an online support group for romantically unsuccessful people of all genders in the 1990s, and turned into a male-only community in the 2000s-2010s, before being banned from most mainstream social media platforms (Bachaud, 2025).

Today, incels mostly congregate on community-specific forums, notorious for their open misogyny, racism, homophobia, and antisemitic conspiracy theories (Beauchamp, 2019). The dominant incel ideology is called "the blackpill*." Typically, this philosophy includes, as core beliefs, that physical attractiveness is largely genetically determined and that men's physical appearance is the decisive factor determining their sexual and romantic life (Radicalisation Awareness Network, 2021). It follows from these two axioms, "that a man's dating and life outcomes generally rely on genetically determined traits" ("Scientific Blackpill," n.d.). To be considered an incel by the community, one must therefore be a heterosexual man who desires a romantic/sexual relationship but is unable to enter one, usually with no past sexual experience (recourse to paid sex work notwithstanding; Bachaud, 2024).

As an online community of pseudonymous individuals, it is difficult to gather high-quality geographic data on incels. A counter-terrorism report was able to determine the European origins of incels.is forum users by analyzing forum posts (Radicalisation Awareness Network, 2021, p. 13), and a Twitter dataset allowed to geolocate US zones with the highest proportion of tweets using incel terms (Brooks et al., 2022). Although community registration and participation are not restricted to any location, it appears that English-speaking incels are mostly based in North America and Europe.

Qualitative discourse analyses have revealed the emotional distress present among incel communities, emphasizing rage and self-loathing (Labbaf, 2019), shame and resentment (Cottee, 2021), as well as helplessness and hopelessness in the cases of incel mass killers (Williams & Arntfield, 2020). Survey research has confirmed the severe mental health situation among incel respondents. Depression is commonplace, with a survey of 274 incels respondents finding that 95% report "some depression" and 37% self-report a formal clinical depression diagnosis (Moskalenko et al., 2022). Other studies using the PHQ-9 scale found that moderately severe and severe depressive symptoms were common among incels, with prevalence rates of 38.9% in a sample of 561 respondents (Costello et al., 2025). A controlled study also found higher rates of depression in the incel group ($n = 72$) using the DASS scale (Delaney et al., 2024). Furthermore, 43% of incel survey respondents ($N = 561$) scored moderate to high for anxiety on the GAD-7 scale (Costello et al., 2025). Autism Spectrum Disorder (ASD) is also much more prevalent among incels, with the largest survey to date ($N = 561$) finding that 30% of respondents met the threshold for clinical ASD referral (Costello et al., 2025). Suicidality is extremely high among incel communities too, as shown by the prevalence of suicide notes on incel forums (Daly & Laskovtsov, 2021), as well as widespread self-reports of suicidal ideation in a recent survey ($N = 561$), including daily suicidal thoughts for more than a fifth of respondents (Costello et al., 2025). Other concerning findings pertain to severe isolation, with 82% of incel survey respondents ($N = 561$) reporting never interacting face-to-face with friends (Costello et al., 2025). Also of note are incels' low self-esteem and higher rates of insecure attachment styles (Sparks et al., 2024).

Many researchers have called for referring incels to mental health professionals, and for designing targeted interventions (Broyd et al., 2023; Costello et al., 2025; Maxwell et al., 2020; Sparks et al., 2022; Van Brunt & Taylor, 2020). However, there has been to our knowledge no thorough empirical assessment of incels' existing attitudes towards psychotherapy, nor of their experiences with mental health professionals. The only exception so far is a long-form 68-item survey of 274 self-identified incels, which comprised three items on therapy (Moskalenko et al., 2022). While 51% of respondents reported ever going to therapy, only 6% reported subsequent improvements in mental health, while the rest reported "no change" or even feeling "worse" as a result (15%). The present study aims at consolidating these findings via targeted mixed methods analysis.

Englar-Carlson et al. (2010) acknowledge the hurdles posed by men's specific reluctance to engage with psychotherapy, and advocate for therapy informed by understanding the cultures of

masculinity. Along with Seidler et al. (2018), they call for sociologically-informed psychotherapy which recognizes the specific challenges to mental health intervention posed by different conceptions and experiences of masculinity (e.g., African American, working-class, gay). With their blackpill ideology, distinctive jargon, and insular online spaces, incels have been described as representing a specific form of masculinity (Ging, 2019; Menzie, 2020). Following calls for sociologically-informed psychotherapy, the present study thus aims to explore incel experiences, attitudes, and potential reluctance to engage with psychotherapy. It addresses two interrelated set of research questions, the first experiential and the second attitudinal:

> RQ1: What experiences do incels report with psychotherapy—including their motivations for seeking support, interactions with therapists, and outcomes?
>
> RQ2: What are the attitudes towards psychotherapy found within the incel community, and how do they relate to engagement with mental health services?

Answering those questions is a necessary step towards designing effective mental health therapy with incel patients—a highly vulnerable yet hostile demographic. In the discussion section, recommendations and directions for successful therapy with incels are suggested.

Methods

Incels are reluctant to engage with researchers or journalists and very protective of their privacy and anonymity (Bachaud, 2025, pp. 90–91, 469–470). Consequently, there is little available interview or survey data to learn firsthand about incel experiences with therapy. However, psychotherapy is a widely discussed topic on incel forums. On these forum discussions, incels recall their therapy sessions, while others comment on them, and everyone shares their general opinion on psychotherapy. This is ideal to understand incel attitudes towards therapy, and this is also the best available data to understand their therapy experiences.

We conducted our analysis on incels.is, the largest incel forum (with more than 30,000 members as of writing in May 2025). We searched for Discussion threads with either "therapy" or "therapist" in their titles, then sorted threads by date of first post. On March 4-6, 2025, we collected the 100 most recent threads, for an up-to-date assessment of community attitudes. We excluded six of these posts on a case-by-case basis, as they did not deal with psychotherapy (e.g., about physical therapy or "therapy pets"). On March 21, 2025, we collected six additional older threads through a similar method, completing a final corpus of 100 threads about psychotherapy.

The corpus contains 2,430 forum posts written by 617 pseudonymous user accounts. The threads analyzed were created between March 12, 2024, and March 12, 2025. To answer RQ1 and RQ2, we conducted an inductive thematic discourse analysis. We uploaded all the threads into Nvivo for qualitative coding, with no pre-established categories to let patterns emerge from the data after careful analysis. After identifying these thematic categories, we went through the corpus again to refine categories and gather examples until saturation was reached, i.e., until it felt that no new insights were gained by reading additional material (Paillé & Mucchielli, 2016, p. 422). We then re-grouped subcodes into larger codes, which constitute the main themes of the analysis presented in this paper (for similar methods in incel research, see Burns & Boislard, 2024). Underlying this analysis was the ethnographic knowledge of our first author, who has been studying incels for the past five years (see Bachaud, 2025).

To supplement the qualitative analysis and specifically address RQ1, we also constituted an incel patient dataset for quantitative description. During analysis, each user who unambiguously reported attending mental health therapy (i.e., psychiatry, psychotherapy, group therapy, or mental health hospitalization) was systematically added to the dataset ($n = 89$). Two independent raters (LB and MM) then coded categorical variables based on all corpus posts written by these incel patients. These variables included gender of therapist (*Man*/*Woman*/*Unspecified*); motivation to attend (*Forced*/*Convinced*/*Volitional*/*Unspecified-Unclear*); and reported satisfaction level (*Negative*/*Positive*/*Unspecified-Unclear*). Prior to independent coding, the two raters jointly coded a training subset comprising 10 of the 89 cases to familiarize themselves with the coding criteria and ensure consistent application (see Neuendorf, 2012, p. 226). They discussed and resolved discrepancies through consensus, and accordingly refined the Coding Dictionary (reproduced in Appendix 1). They then independently coded the remaining 79 cases, and calculated interrater reliability and interrater percentage agreement on these 79 cases (see result details in Appendix 2, and R code in Appendix 4). After this, the two coders discussed to reach agreement for every case of disagreement throughout the dataset. The final anonymized dataset with all coded variables is provided in Appendix 3.

Reflexivity statement: All three authors are men with extensive knowledge of incel ideology. LB has

published several qualitative analyses of incel discourse, including critique of their pseudoscientific beliefs. AT has conducted extensive primary data collection with incel communities, notably investigating their mental health. He is also a psychotherapist who has clinical experience with incel patients. MM is a researcher who has done prior work, both inside and outside academia, to push back against harmful incel beliefs, especially their misrepresentation of evolutionary psychological science. While they have been publicly critical of certain incel beliefs, they also are concerned about incel depression and suicidality, for which they want to find evidence-based solutions. This study was born out of noticing a gap in scholarly literature: recommendations for mental health interventions are plentiful, but they usually neglect incels' particular therapy experiences as well as community attitudes towards psychotherapy.

All the threads analyzed are freely and publicly available without registering on the forum. Yet, the forum is well-known and indexed, and the mental health issues discussed therein are sensitive. To protect user privacy, we kept usernames anonymous and the quoted material contains no personally identifiable information. Words specific to incels' distinctive jargon are marked with an asterisk, and their definitions are provided in Appendix 5 (incel lexicon).

Results

RQ1: Incel Experiences with Therapy

Descriptive Statistics

In total, 89 anonymous forum posters reported past or current engagement with psychotherapy. For these incel patients' satisfaction with their therapy experiences, excluding the training subsample, the two raters agreed on 84.8% of cases, and Cohen's κ indicated this agreement was substantial ($\kappa = .69$, $p < .001$). Out of these 89, 61 (68.5%) exhibit negative attitudes towards their therapy experience, with a majority reporting frustration or anger at the absence of tangible mental health improvement, and others even blaming therapy for worsening their mental health. Only 7 respondents (7.9%) reported satisfaction, while 23.6% of testimonies did not include sufficient details to allow for coding. These results align with previous survey findings from Moskalenko et al. (2022). In that study, a small minority of incels reported satisfaction with their therapy experiences, while a majority found it useless or even detrimental.

The gender of one's therapist is a very prominent feature of incel discussions on therapy. For this variable, excluding the training subsample, the two raters agreed on 89.9% of cases, with excellent agreement ($\kappa = .84$, $p < .001$). Here we found that 28 incels who had followed therapy report having a female therapist (31.5%), 18 a male therapist (20.2%), and the rest of the testimonies did not unambiguously specify therapist gender (48.3%).

Finally, for incel's motivation to attend therapy, excluding the training subsample, the two raters independently agreed on 84.8% of cases, and Cohen's κ indicated this agreement was substantial ($\kappa = .73$, $p < .001$). Remarkably, a quarter of incel patients (25.8%) report being "forced" into attending therapy. This aligns with research showing that men often believe they are coerced into attending therapy (Englar-Carlson et al., 2010), which is associated with poorer outcomes (Snyder & Anderson, 2009). Half of those mention being forced by their parents, or more rarely by the authorities, after attempting suicide, or as a required step to collect government benefits (for the operational definition of "forced" used by coders, see Coding Dictionary in Appendix 1). Four respondents (4.5%) report being convinced by a third party, without clear indication of coercion. It is much harder to determine whether one's involvement with therapy was voluntary, although 8 incels unambiguously specify that they sought out mental health assistance themselves (9.0%). In a majority of cases, motivation for engaging was not clearly specified (60.7%). The anonymized dataset with all coded variables is provided in Appendix 3.

Potential Drivers of Patient Satisfaction

Figure 1 above presents the descriptive statistics for reported therapy experiences by therapist gender. While statistical power was limited due to small sample sizes and very low rates of positive experiences (i.e., 2/28 [Female] vs 3/18 [Male]), the observed pattern was consistent with the hypothesis that participants reported higher satisfaction with male therapists (discussed below). However, after running a one-tailed Fisher's exact test to assess this unidirectional hypothesis, the result was not significant ($p = .29$, OR = 2.54, 95% CI: 0.26-33.7), though the wide confidence interval indicates considerable uncertainty around the effect size estimate.

Additionally, none of the 23 participants who recalled being forced into therapy reported positive experiences (0%, 95% CI: 0-14.3%), compared to an overall positive rate of 10.6% (7/66) for those who were not forced (95% CI: 5.2-20.3%). While

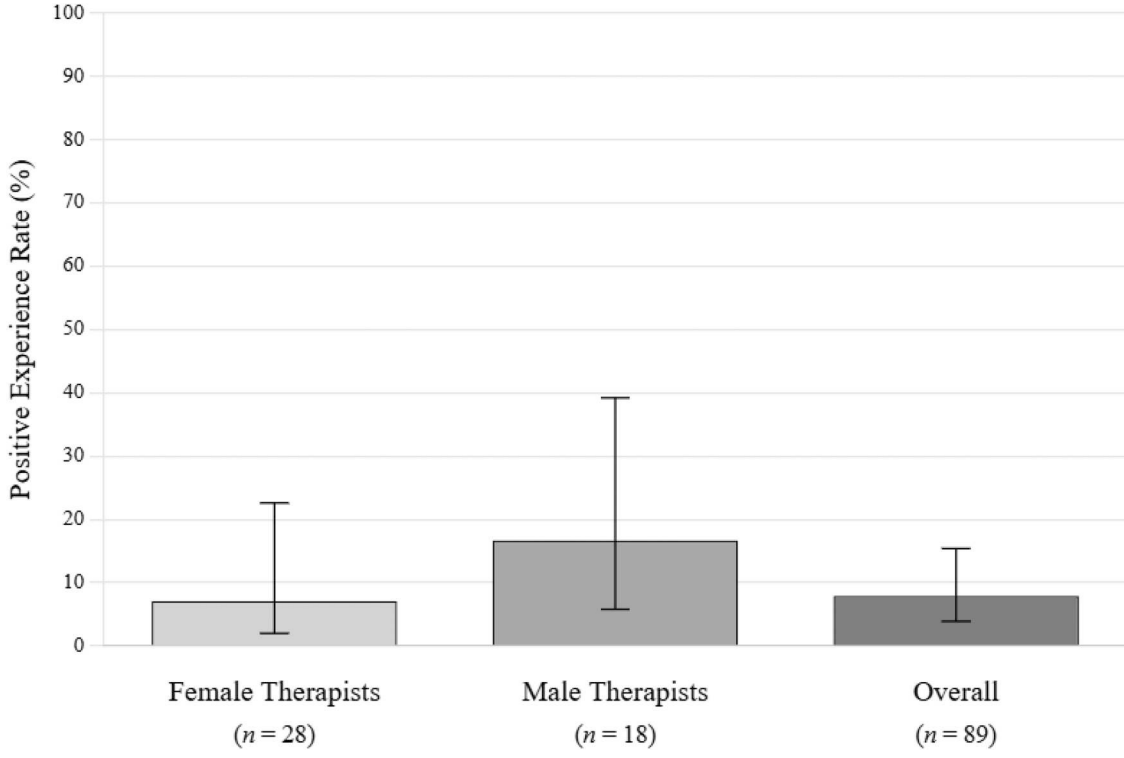

Figure 1. Incel's Reported Therapy Satisfaction by Therapist Gender. Error bars = 95% confidence intervals using the Wilson score method.

this difference did not reach statistical significance due to low satisfaction rates (Fisher's exact test, $p = .11$), the large effect size (Cohen's $h = 0.66$) suggests a meaningful clinical difference warranting further investigation.

Exploring Incel Patients' Positive Experiences

The seven patients who reported somewhat positive therapy experiences wrote a total of 44 forum posts. By closely analyzing these posts, we can identify factors which were conducive to establishing rapport between patients and therapists and to addressing mental health issues.

Firstly, these incels did not seem to enter therapy with the expectation that it would solve all their problems, or that it would help them leave inceldom (i.e., lose their virginity). They instead report going to therapists for specific conditions such as OCD, PTSD, loneliness, or hypochondria. They acknowledge that therapy helped alleviate these mental health issues, although they remind others that therapy cannot be expected to solve sexual frustration or make one more romantically attractive: "never ask a thERapist stupid shit he can't do for me, like 'please, doc, turn me into a young sexy billionaire', it doesn't work like that." Even though these few incels report somewhat positive therapy experiences, none of them is overly enthusiastic about psychotherapy's ability to address incel-specific issues. According to this user, one of the only psychotherapy advocates on the forum, it should just be seen as a useful coping mechanism to enjoy a life of involuntary celibacy: "This is what therapy is good for: to teach you how to cope with your sexless life. Therapy won't make you become more sexy."

Four of these seven testimonies specify that the therapist was male. Some mention that they appreciated qualities in their therapists that incels tend to associate with men: intelligence, lack of political correctness, and blunt honesty ("i had one really good therapist, who didnt give a fuck about being soft or welcoming, he always told me straight up what he thinks about my views and my life."). In fact, some explicitly attribute the success of their therapy to their therapists' gender: "he was the best and honestly helped me alot, i was going for a year. but every female therapist was not helpful and i stopped going to them after a few sessions (After honestly giving them a chance)." Even the aforementioned therapy advocate recognizes that therapy for incels cannot work with female or politically correct liberal men. As for the user who explains appreciating sessions with his female therapist, he acknowledges that this is due to his romantic/sexual attraction

towards her: "my therapist I find is quite hot and very dorky. I never get female attention in the first place, so having a chick I talk to on the weekly has actually been quite nice."

In summary, although they personally report satisfaction, these incels embrace common community beliefs: i.e., therapy is not effective at solving inceldom and is at best a "coping" strategy, and male therapists are to be preferred over female therapists. They, however, do not share the blatant hostility of other users for mental health professionals, nor the conspiracy theories embraced by many.

Exploring Incels' Negative Experiences

When incels come to a therapist's practice, if they manage to overcome the shame caused by the stigma around virginity, they will likely want to address their involuntary celibacy. Indeed, it is almost by definition seen by incel patients as the root cause of their mental health issues. However, psychotherapists may not be prepared to address the romantic and sexual concerns that incels prioritize. According to testimonies from incel patients, therapists seemed puzzled and unable to address the issue of late virginity: e.g., "Brutal when I told the therapist I was a 30 year old virgin she didn't have a clue what to say just sat there and she moved on"; "He just nods his head and says 'damn' and doesn't know what to say."

Furthermore, some incels report being infuriated by the dating advice provided by their therapist, which they view as platitudinous and unhelpful. Indeed, incel blackpill ideology emerged as a reaction to such dating advice, known in the community as the "bluepill*." The incel wiki (incels.wiki) defines the bluepill as what the "normie* fakestream media, similar conventional sources, and associated platitudes […] have to say about the dating scene" ("Bluepill," n.d.). Incels use this umbrella term to designate common tropes that directly clash with the blackpill's fatalism: optimism about dating, the idea that there "is always someone out there," and that looks do not matter if one has an attractive personality. This sort of optimistic advice is a common locus of conflict between incel patients and their therapists (and with non-incels in general, see Maxwell et al., 2020). For example, this incel recalls trying to convince his therapist that he was ugly, and that looks played a part in romantic success, which she allegedly kept denying: "I basically then moved away from that angle and tried to get her to at least agree that attractive people do better in dating, which should genuinely be common sense even to bluepillers, and this bitch said attractiveness was all subjective and that she didn't find brad pitt to be attractive."

Consequently, most incel patients report that the therapeutic process was useless for them: "The actual talk therapy did absolutely nothing with the ~30 therapists I worked with"; "I went to three separate therapists (one of which was a "psychotherapist" but they all may as well be the same as far as I'm concerned), and none of them helped. Therapy and psychology could not help me as an incel." As we discuss below, this is mostly caused by the incel perception that their dating issues are caused by immutable and/or external factors, which therapy is simply unable to address. Beyond this perception of uselessness, which is almost unanimous among incels reporting negative therapy experiences, a minority of incels even blame therapy for worsening their mental health.

RQ2: Incel Attitudes Towards Psychotherapy

"No Therapy for your Face": Why Blackpilled Incels Reject Psychotherapy

In blackpill ideology, incels attribute their celibacy to features which they consider to be universally repellent to women. Some insist on height, some on ethnicity, and some on their autism for example. To each of these features corresponds a label and archetype of incel, e.g., "shortcel" for height, "currycel" for Indian ancestry, or "spergcel" for autism. The blackpill is particularly fatalistic, as incels believe that, being born with these traits, they "lost the genetic lottery" and are therefore doomed to a life of celibacy and sexual deprivation (Radicalisation Awareness Network, 2021). These traits tend to be highly heritable and immutable, while other traits like obesity (which incels perceive as more easily modifiable), are often not considered as valid causes of inceldom within the community (Bachaud, 2024).

The blackpill's strong genetic determinism and focus on appearance (height, face, skin color, etc.) has a massive influence on incels' sense of self. While most of them report some form of mental health issue, these are usually seen as consequences of sexual rejection and deprivation, which are themselves caused by immutable innate traits. In summary, most blackpilled incels subscribe to the explanatory causal model schematized in Figure 2 below.

This simplistic framework does not allow for much nuance and severely hinders therapy-seeking among incels. Indeed, since mental health issues are thought to be a mere consequence of sexual rejection, incels repeatedly argue that psychotherapy cannot

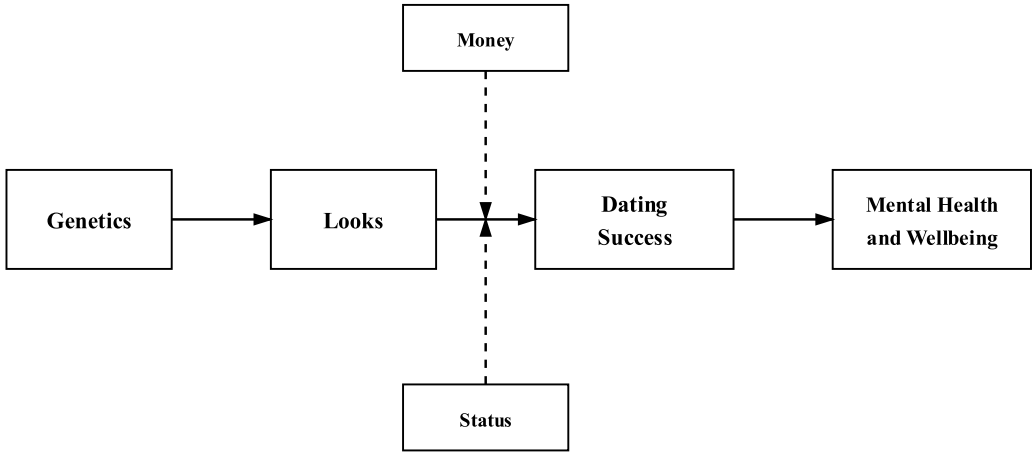

Figure 2. The Blackpill's Causal Model of Mental Health and Life Satisfaction. Note: Money and status are sometimes held to be determining factors for dating success in blackpill ideology, albeit much less so than looks (Radicalisation Awareness Network, 2021, p. 5).

address the deep genetic and physical causes which make them unattractive and thus unhappy. A motto which surfaces time and time again is "no therapy for your face" or "no therapy for your height." There is widespread agreement among incels that the causes of inceldom are so potent and immutable that no amount of therapy could ever address them, e.g.: "Therapy won't change your facial structure and height"; "Therapy is pointless for us because we can't actually fix our problem, I need plastic surgery and a NT [neurotypical] brain."

The blackpill is a potent set of beliefs whose inherent fatalism deters most help-seeking behaviors. According to a survey on incels.is ($N = 272$), 94.9% of users believe in the blackpill, and 71.3% believe that their sexual deprivation will remain permanent (Speckhard et al., 2021). When, in spite of their reluctance, some incels decide to engage with psychotherapy, they are thus coming to the sessions with a strong explanatory framework for their life situation and mental health. This makes them very resistant to alternative explanations potentially offered by therapists, e.g.: "My problems are real and I have had them for decades. I have pondered them and considered all possible solutions since I was a teenager. There is no way some therapist is going to be able to provide something I haven't already thought of."

Often, the blackpill's fatalism directly clashes with therapists' assessments, which tend to be more growth-oriented, solution-seeking, and optimistic. In most cases, this challenging of the incel worldview is met with anger, as therapists are accused of "gaslighting" incel patients. Sometimes, incels even try to "blackpill" their therapist, i.e., to convince them of the immutability of their situation: "I Blackpilled* mine so she knows its over for me, I pulled up all the data and all the facts."

These analyses reveal that incels could prove to be a difficult population for psychotherapy intervention. Indeed, they are extremely self-reflexive and have pre-established mental models and causal explanations for their situation. These explanations (i.e., "the blackpill") structure their sense of self and their community engagement, and can be fiercely defended when challenged. Moreover, some incels have a strong interest in science leading some to see their beliefs as supported by the scientific literature (Bachaud, 2025). Some therapeutic modalities, like Cognitive Behavioral Therapy, focus on encouraging patients to begin using evidence to challenge and evaluate thoughts and beliefs (Beck, 2020). Incels pre-existing relationship with "evidence" may make such interventions all the more challenging for therapists, particularly if they are unaware of how the research incels refer to is cherry-picked and misinterpreted.

Defiance and Conspiracy Theories

One of the most common and damaging beliefs about psychotherapy circulating on the forum is that therapy is a mere scam. Given the ubiquitous blackpill beliefs about the uselessness of therapy, the commercial nature of the patient/therapist relationship is often taken as irretractable proof that psychotherapy is an illegitimate and unscrupulous industry: "'therapists' are basically Glorified Con Artists JFL [just for laughs]." This trope is extremely popular on the forum and is often associated with criticisms of pharmaceutical companies, which are thought to be behind this scam: "The mental health industry is a con created by big pharma to exploit mentally vulnerable people."

Indeed, psychiatric medication is almost unanimously framed on the forum as harmful, with some incels testifying about the undesirable side effects they have experienced with them: "it kinda fucked me over too tbh [to be honest] i was put on ssris when i was a teenager and stayed on them for a couple of years and it didnt do my brain any good"; "im literally asexual now. literally cant even feel attracted to women anymore and 0 libido." These beliefs tie in with existing literature on men's reluctance to use medication, which they might perceive as a threat to their masculinity and a loss of control (Seidler et al., 2016, p. 114).

These beliefs can lead to various conspiracy theories about psychotherapy. Chief among these are antisemitic conspiracy theories, which hold that the psychotherapy and pharmaceutical industries are controlled by "Jewish elites." In fact, so popular is this belief that psychiatric medication is often dubbed "joopills," "jewpills," or "kikepills" on the forum: e.g., "Therapy is one big scam organized by pharmaceutical companies so they can get people hooked on kikemeds and keep them returning for money."

Often, this conspiracy theory goes further, as these pills are seen as a way for the "Jewish elites" to weaken and feminize (i.e., "castrate") men, and in particular incels, so that they accept their subaltern social position: "Conspiracy theory, they have the quest to give out joopills to castrate and calm lonely men down so they wont go for revenge."; "They want us to be Zombified by taking Jew meds" (for analysis of similar incel antisemitic conspiracy theories about endocrine-disrupting chemicals, see Bachaud, 2025, pp. 335–337). The side-effects of psychiatric medication are here seen as an indication that the "elites" are trying to sedate their population into becoming docile workers: "The point of psychiatry isn't to help you, but to brainwash you into becoming a good productive goy again via 'therapy' and kikepills."

This conspiracy theory has many variants, which might not all be antisemitic. Sometimes, therapists themselves are seen as the orchestrators of the scam, sedating people so that they keep on spending their money on therapy sessions. And in most instances, the obscure force behind this is simply referred to as (1) "the system"; (2) "society"; or (3) not even explicitly named, as illustrated by the following examples: (1) "these therapists only care that you are a loyal slave/servant of the system and that you don't 'complain'"; (2) "Therapy serves no purpose, only to mould docile subjects into a society that will only want to exploit you"; (3) "So you can get mind controlled and stop seeing the world for how it is, be a better slave."

Given the popularity of these conspiracy theories, it is perhaps no surprise that we could not find any positive trope or belief about therapy or psychiatry in our qualitative analyses of the forum content. These are simply seen by many incels as anathema to their community, as a form of social and chemical control which they fear, resent, and are often forced into. It is unclear how mental health professionals could address these broad conspiracy theories, which are deeply rooted in the community's worldview. Below, we identify some additional incel concerns and beliefs about therapy which might prevent them from seeking mental health assistance. Those are more practical concerns, which might be easier to address.

Additional Concerns Dissuading Therapy-Seeking: Cost, Privacy, Hospitalization, and Shame

Our analyses revealed that Incels share common fears and concerns about seeking mental health intervention. A recurring practical concern is the price of therapy sessions, as in the example of this poster who was hesitant to engage with therapy: "My mother and Psychology prof said I should take it but im not sure because that shit costs a lot of money. Like they want me to pay them $200 per WEEK and i know its just shit talk." Given the reigning skepticism regarding the benefits of psychotherapy, session prices are often seen as a major hurdle for attending, if not as an outright proof that therapy is a scam. This seems to be particularly salient for those incels who might want to attend: "No idea about therapy, i could use some … if it was free. Im not gonna spend hundreds of dollars on copetalk." In fact, several incels report attending therapy solely because it was subsidized by parents, government benefits, or insurance.

Another salient concern is privacy. Indeed, as the community has inspired some mass shootings since the 2010s, it has come under increasing scrutiny by police and antiterrorism forces. As a consequence, several posters report feeling unable to speak their minds during sessions, e.g.: "It's not like you can actually talk about the problems that you face on a daily basis because they would probably flag you for being a threat to society or whatever cuck* shit they do." Privacy concerns include fear of the therapists' notes being leaked, hacked, or used in court. But the most common fear is that of being reported to the police for radicalization or terrorism: "Be careful. Therapists will report you to the police if you're both depressed and misogynistic. Happened to someone I knew." Therapists are often portrayed

as direct informants to the authorities ("glorified KGB informants"), prompting this forum poster to take confidentiality measures to attend therapy: "I used a fake name, fake address, and paid anonymously so he can't call the cops on me."

Along the same lines, being sent to a psychiatric hospital is also a common fear that incels report when considering seeking mental health therapy, e.g.: "im thinking of being truthful about everything i say, will i maybe be put on a list or thrown into an asylum?" Even for those engaged in therapy, this fear prevents them from opening up, such as this poster who did not dare share his violent thoughts during therapy: "Had to hold in my laughter or else i would've been sent to the clown house jfl."

Lastly, a surprisingly high number of incels seem convinced that psychotherapists, in particular women, are secretly mocking them: "I'm reasonably sure all female therapists are mocking you inside their heads if you're their incel client." A recurring trope is that of the female therapist laughing about incels with her own boyfriend: "The moment you leave they'll call their chad* boyfriend and make fun of you." This attitude is grounded in the incel worldview, which strictly differentiates between incels and the rest of the population (i.e., "normies*" or "sex-havers"). Incels see these normies with envy for having regular sex, but also with hatred for not empathizing with the hardships of being an involuntary celibate. Compounded with the existing stigma around male virginity, this makes incels approach therapy with the expectation that they will be automatically judged and shamed by their therapist for being virgins. In fact, on incels.is, psychotherapists are routinely portrayed as devoid of empathy and understanding.

Lack of Understanding and Empathy

There are two related beliefs on these issues circulating on the incel forum. The first one being that therapist, as "normies*," cannot relate to the life of an incel, and are thus unable to understand their situation: "Attending therapy sessions has never worked for me, these therapists and mental health councilors never understand, nobody outside of this forum understands my Inceldom." A more widespread version of this trope holds that not only do therapists not understand, but moreover that they simply do not care about incels' lives.

The empathy of psychotherapists is questioned by no less than thirty different posters. The dominant view is that psychotherapy is just a job, and that therapists thus have no genuine interest in helping out people: "They only talk to you as their job. They would hate you and bully you in their own life." The verbs "pretend" and "care" are a recurring feature of these comments, who agree on the fact that therapists are just faking empathy for money.

Here, as in their discussions about sex work, incels put a lot of emphasis on craving genuine and sincere relationships. Indeed, even if a minority of incels (called "escortcels") satisfy their sexual urges through paid sex work, most reject this option because they desire a non-commercial sexual relationship driven by genuine attraction (i.e., "being chosen"). Likewise with psychotherapy, the commercial nature of the interaction drives incels to see the therapeutic alliance as compromised and fake: "Therapy is a waste because you're paying someone to care about you and care can't be bought." While this analogy between psychotherapy and sex work might seem unusual, it is in fact relatively common in incel discussions on therapy, where female therapists are almost always sexualized.

Therapist Gender

A recurring topic of discussion concerns the gender of one's therapist. Male therapists are almost unanimously preferred, as in the following piece of advice: "Never ever go to a foid* [woman] therapist, if you are going to get therapy get a male therapist who understands male nature and doesnt go with the 'Be happy alone' shit." Female therapists are widely portrayed on the forum as uncaring, incapable to empathize with male experiences, indoctrinated by feminism, inherently repulsed by unattractive men, or simply as incompetent and stupid. These misogynistic beliefs raise doubts regarding the possibility of establishing successful therapeutic alliances between incel patients and female psychotherapists.

Moreover, when female therapists are discussed, they are almost always sexualized. Since incels see virginity as the defining feature of their identity, as well as their social and mental hardships, female therapists' sexuality is often fantasized as a potential "cure" for inceldom, e.g.: "Foid therapists should give pussy to cure my depression." One finds dozen iterations of this trope on the forum, where incels revel in graphic sexual ideation regarding female therapists, including six mentions of rape (e.g., "Foid* therapists are better because you can rape them."). Female psychotherapists are also often unfavorably compared to sex workers, as both offer expensive fixed-time sessions supposed to make one feel better: "If you're going to pay ludicrous amounts of money for emotional prostitution you might as well go all the way and get an actual prostitute."

Sometimes this misogyny and objectification might translate into behavior. Accounts from the forum include a patient who claims to have solicited sexual favors from his therapist: "I was honest with my therapist and care manager that I wanted to have sex with them and that was the only way they could help me, and that led to me getting banned from the facility along with a protection order." Another poster conferred with his fellow users on the best way to covertly take a picture of his female therapist to use as masturbation material. Lastly, one claims to have slapped his therapist when he was eighteen: "i slapped my foid* therapist—she didnt even harass me kek [lol] but i was annoyed at my parents for forcing me into this bullshit and i just had to take it out on someone kek."

Therapy as a Female-Biased and Feminist Profession

In a recent survey ($N = 561$), incels ranked feminists as the community's biggest enemy, followed by the political left (Costello et al., 2025). On incels.is, therapy is routinely associated with those two enemies—e.g., "therapy = pay 6 gorillion/hour to talk to some dumb blue haired liberal feminist foid* who secretly hates you." As college-educated and mostly female professionals, therapists are automatically assumed to be liberal and feminist, which is a powerful deterrent for incels to seek therapy. These beliefs are particularly aggravated by the use of words from feminist theory in official APA guidelines (such as patriarchy), or by concepts such as toxic masculinity which are seen as hostile towards men: "They are heavily educated in the modern liberal doctrines too that gaslight men for feeling masculine feelings (anger dominance and logic) and portray any actions involving these as bad despite that not being the case." Thus, our corpus contains several examples of feminist pronouncements by mental health professionals, whether in their official literature, or on their private social media, which are taken by incels as evidence of the field's feminist bias and hostility towards men.

This ties in the broader idea that therapy is simply not meant to help men, a very common belief on the forum, e.g.: "therapy is a foid* centric field and biased to them. It is only to help them." This *leitmotiv* is often complemented by claims that (1) women's issues are mild or illegitimate compared to incels' ("Therapy works best for spoiled white women who don't have real problems"); (2) women therefore simply go to therapy to hear someone reassure them and to feel better about themselves ("Therapy is a scam. It's just reassurance for women"). Often, this view of women's reliance on therapy is contrasted with the more intractable issues faced by incels, which therapy is deemed incapable of solving: "The rapy [*sic*] isn't designed for men like us, it's made for dumb roasties* [women] who pretend to be victims to have their fake 'problems' be 'fixed' by someone telling them 'actually it's okay!'. Therapist can't get you a gf so they can't fix inceldom, they are useless for men's problems." These incel beliefs are aligned with broader experimental findings revealing that psychological health-seeking behaviors are perceived as feminine (McCusker & Galupo, 2011; Seidler et al., 2016, p. 114).

Discussion

Towards Effective Psychotherapy with Incel Patients

Our mixed methods analysis of incels' experiences with and attitudes towards therapy reveals a particularly challenging landscape for intervention with this community. At best, psychotherapy and psychiatry are widely regarded as useless. At worst, they might even be considered malevolent and harmful. Moreover, incels have a suite of inhibitions and fears which make them reluctant to engage with mental health professionals. In spite, of this, given their life histories and precarious mental health, many have in fact attended therapy, albeit not always of their own will (25.8% report being forced). Incel patients overwhelmingly report negative experiences with the therapeutic process (68.5%). These negative experiences then spur more hostility, as those disgruntled incels then report their experiences to others online, and loudly advocate against psychotherapy. In this section, we reflect on potential solutions to address this challenging state of affairs.

Firstly, the analyses presented in this paper suggest that male therapists should be preferred when dealing with incel patients. While this suggestion of course does not imply accepting the misogynistic and depreciatory view of female therapists endorsed by the community, it stems from the acknowledgment that this view has profound consequences on incel thinking and behavior. The extreme misogyny of the community does not seem conducive to the establishment of a successful cross-gender therapeutic alliance, as female therapists are automatically suspected by incels of being feminist, biased, hostile, incompetent, uncaring, mocking, etc. Furthermore, they are also routinely sexualized, thus diverting attention from the therapeutic process. Lastly, we also have also uncovered evidence that interacting

with incel patients might put female therapists at higher risk of being targeted with verbal, if not physical, abuse. It must be noted however that incels have listed feminists and the political left slightly above women as their main enemies in a recent survey study (Costello et al., 2025). This suggests that the suspiciousness against women described here might be confounded by general hostility towards progressives. This is exemplified in this testimony of an incel who recalls being disappointed at his male therapist's perceived liberal appearance ("soyboy" being a common term for supposedly effeminate liberal men): "I walked in and it was a literal soyboy*. Ruins the entire point of asking for a male therapist."

Secondly, given incels' distinctive worldview, it appears crucial for therapists to understand the core beliefs of the blackpill, especially since incel patients themselves might be reluctant to disclose these beliefs for fear of being seen as radical or dangerous. We hope the present study will contribute to this, but there are many other ways for mental health professionals to be informed, as incels have been extensively covered in the press (Beauchamp, 2019), popular science books (Sugiura, 2021), academic publications (see a review of incel research in; Bachaud, 2025, pp. 79–93), government reports (Radicalisation Awareness Network, 2021), or a TV documentary (Rawles, 2019). At the same time, therapists should be particularly mindful about building empathy with incel clients and understanding their frame of reference. Because incels typical believe that society hates them and doesn't empathize with them (Costello et al., 2022; Costello & Thomas, 2025) additional effort needs to be made to ensure that the core conditions are met within the therapeutic relationship (Rogers, 1957).

Thirdly, when treating incel patients, psychotherapists who are not specialized in romantic and sexual matters might want to explicitly acknowledge it. If incels come to conventional therapy with the expectation that they will find a romantic/sexual partner, they are likely to be disappointed. Such expectation is misaligned with the training and aims of psychotherapists. In fact, our analyses revealed that those who reported positive experiences seemed to specifically be those who did not come in with that expectation. Consequently, therapists might want to engage in a therapeutic alliance with clearly defined and limited objectives, such as dealing with anxiety or depression. Such objectives could be framed as serving wider goals of coping better with singlehood, or building resilience to the challenges of finding a relationship. This follows recommendations from the academic literature on fostering engagement with male patients, which often insists on establishing a structured, transparent, goal-oriented gameplan for intervention (recommendations reviewed in Seidler et al., 2018). This is not without its challenges, incels are very avoidant in attachment and are almost personality-disorder-like in their schemas (Young, 2002). These types of issues often require long-term treatment from several different angles. Incels may also arrive at therapy in a stage of precontemplation which would need to be worked through before setting coherent goals (Prochaska & Velicer, 1997) and motivation for change might need to be addressed through methods such as motivational interviewing (Rubak et al., 2005).

Many incels see virginity as the root cause of their mental health issues, leading to skepticism towards therapy which does not directly address the issue. This is why therapists should also reflect on the sociological and psychological dimensions of virginity. Indeed, late sexual onset and adult virginity are on the rise in contemporary Western societies (Twenge et al., 2017; Twenge & Park, 2019; Ueda et al., 2020). Regardless of their affiliation with the incel community, men who involuntarily undergo adult virginity experience a range of adverse psychosocial consequences, in terms of subjective wellbeing, self-esteem, anxiety, social adjustment, or sexual behavior (for a review, see Stijelja & Mishara, 2023). Given recent sociodemographic trends, such patients will become more common, warranting increased attention from both psychology researchers and clinical practitioners.

To be clear, it is not the function of psychotherapists to take on the role of "date coach" to help incels attract romantic partners. However, it could be appropriate for psychotherapists, and particularly those using models emphasizing attachment and/or behavioral change, to support patients overcome broader issues that prevent them from starting, developing, and maintaining social relationships. Incels have high levels of neurodiversity (Costello et al., 2025) and insecure adult attachment (Sparks et al., 2024) that can act as barriers to meaningful relationships with family, same-sex friends, and work colleagues. Psychotherapeutic work focusing on these issues could lead to a better social support network and improved mental health. It might also support deradicalization by facilitating experiences which challenge inaccurate blackpill narratives about others. Such changes may also, over time, allow former incels to engage in meaningful and healthy romantic relationships.

Lastly, incels' reluctance and hostility towards therapy should not be understood in a cultural vacuum. Scholars have argued that incels in fact embody contemporary trends of online masculinity and misogyny, albeit in the most radical and extreme form (Tranchese & Sugiura, 2021). And they do not represent the only culture of masculinity where resistance to psychotherapy is common (Seidler et al., 2016). Thus, the present findings call for increased attention by mental health professionals towards men in general, both in terms of developing gender-sensitive therapy, and in terms of outreach to address potential barriers that prevent men from accessing mental health services (such as the "Real Men. Real Depression." campaign in the US; Rochlen et al., 2006). Such broad outreach might be unable to sway opinions among the most ideologically driven incels found on the incels.is forum. Yet, it might still help dispel common misconceptions about therapy shared by incels and other cultures of masculinity (i.e., "therapy/depression is for women"; or "therapy is for people with no *real* issues"), ultimately paving the way for a cultural climate more favorable to men's help-seeking. Indeed, incels are part of a broader online galaxy of men's communities known as the "manosphere," with which they share certain tropes and beliefs (Ribeiro et al., 2021; Bachaud, 2025, pp. 67–79). Although virtually nothing is known about mental health in non-incel manosphere groups, gender-sensitive therapy might also foster therapy engagement and positive outcomes with those communities.

Figure 3 below recapitulates this study's findings and this section's suggestions regarding incel therapy engagement.

Limitations and Future Research

Our data allowed to code for a dataset containing patient satisfaction, therapist gender, and motivation to attend therapy. Unfortunately, the small counts and low event rates for each of those variables did not allow for robust statistical testing of hypotheses (see power analysis in Appendix 6, supplementary material). Statistical testing with larger sample sizes is thus needed to test the preliminary directional qualitative findings from our study, i.e., male therapists seem associated with higher incel patient satisfaction, and being forced to attend therapy seems to result in negative experiences.

Our selection procedure focused exclusively on forum threads mentioning therapy, which de facto excluded from our analyses incels who have no interest and no opinion regarding therapy. Moreover, such analyses of forum posts only concern active community members, but miss all the potential incels who visit the forum but never post there (called "lurkers"). Additionally, all incel discourse

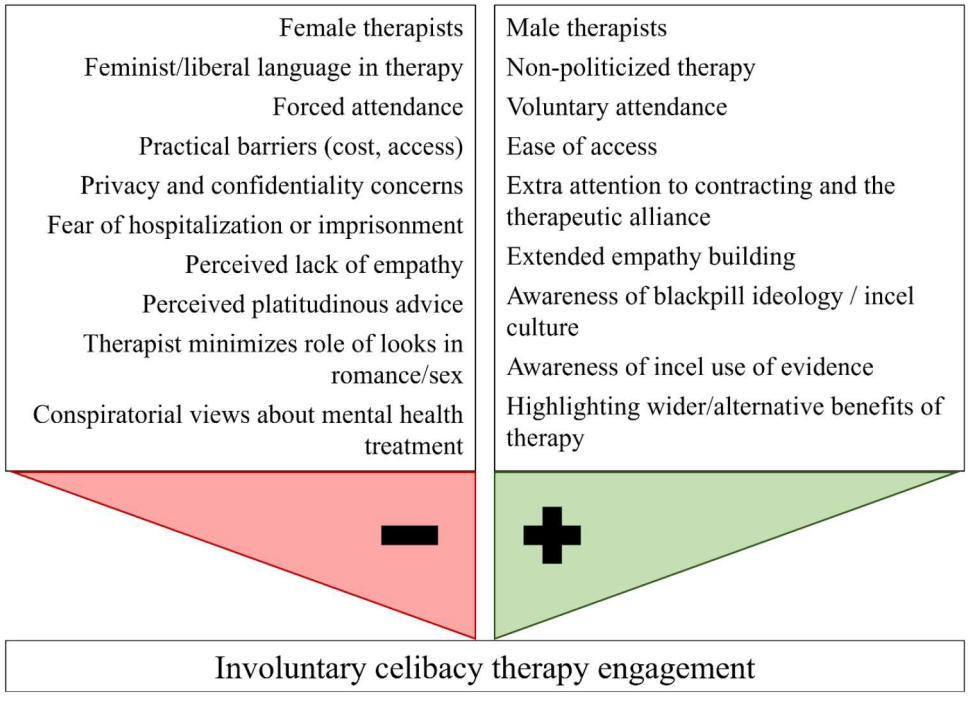

Figure 3. Barriers and Facilitators (+) to Incels' Engagement in Psychotherapy. Note: Barriers (-) are derived from the qualitative analysis, facilitators (+) are derived from the barriers as well as recommendations based on our clinical work with the population.

analysis is to be taken with a grain of salt, as these communities have a distinct culture of exaggeration, bravado, or provocation, known as "trolling" or "shitposting" (Hoffman et al., 2020, p. 577). Lastly, it might be that the almost unanimous hostility towards psychotherapy documented in the present study partly results from a conformity bias, where more positive opinions would not be voiced for fear of condemnation or mockery.

Incels can leave the community by losing their virginity, by reneging on their ideology, or both. By studying the incel forum, one might miss the trajectory of those ex-incels and only focus on individuals with the most radical views and the poorest mental health, i.e., those for whom therapy did not work—a sort of reverse survivor bias. Recently, there has been budding academic interest for the r/incelexit Reddit forum, where former incels congregate and talk about their journey out of the community (Burns & Boislard, 2024; Osuna, 2024). Some testimonies of former incels anecdotally mention therapy as a facilitating factor to leaving inceldom (Burns & Boislard, 2024; Hintz & Baker, 2021). The role of therapy in the trajectories of these former incels should be further scrutinized. This might lead to more optimistic conclusions than the present study which focused on individuals deeply entrenched in the community's belief system.

Social science can help psychotherapists by documenting patients' radicalization patterns, life trajectories, or community beliefs—as was the case with the present study. However, discourse analysis or surveys cannot provide conclusive clinical evidence by themselves. Ultimately, building trust and establishing rapport with incel patients is necessary to design and test effective mental health interventions. Given the reigning hostility towards psychotherapy we documented on the main incel forum, this would require ideologically sensitive outreach towards the community, underpinned by a strong commitment to privacy.

Conclusion

We conducted the first thorough investigation of incel attitudes towards and experiences with psychotherapy. Analysis of posts on the largest incel forum revealed widespread distrust and hostility towards psychotherapy. Through inductive discourse analysis, we identified key themes underlying this hostility: (1) the blackpill belief that immutable factors determine one's dating success; (2) conspiracy theories about therapy as a scam designed to sedate and control men; (3) the perception of psychotherapy as a female-biased profession hostile to men; (4) practical concerns about costs, privacy, and fear of hospitalization.

Coding for categorical variables with the subset of incel posters who recall attending therapy ($n = 89$), we also found that 68.5% report negative experiences, and only 7.9% report being somewhat satisfied. Furthermore, a quarter of these patients recall being forced into attending (25.8%), none of whom report positive experiences. Our findings also suggest that male therapists might be preferable, to establish a therapeutic alliance which is both helpful for patients and safe for mental health professionals.

Ultimately, this study reveals a population caught between desperate psychological need and profound ideological resistance to the very interventions designed to help. While the challenges are substantial, the minority of positive experiences documented here suggest that therapeutic engagement remains possible under specific conditions. As rates of late virginity increase among younger generations, with some of these young men joining the incel community, developing effective approaches to reach this vulnerable population becomes increasingly urgent—both for their own wellbeing and for broader public safety concerns. We call on concerned psychotherapists to develop an understanding of incel ideology, the psychological impact of male late virginity experiences, and contemporary masculinities, as prerequisites to establishing trustful and productive therapeutic interventions. Future research should examine intervention strategies informed by these findings and investigate the influence of therapy on community exit trajectories.

Use of Generative AI

LLM Claude 3.7 (Sonnet) was used to assist with data scraping, formatting for Nvivo and use of the software, and writing (e.g. identifying overly lengthy sentences).

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Supplementary material

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