Silence in The Exam Room: The Cost of Clinical Discomfort

Author: Shanel Pile, LMFT-S

Abstract

This article examines how Black sexuality and kink are often met with discomfort or erasure in clinical spaces. Anchored in personal narrative and supported by current research, it highlights how implicit bias, historical trauma, and provider discomfort impact patient care. Drawing from lived experience and therapeutic insight, the piece argues that tools like the Implicit Association Test and reflective SOAP notes can support more inclusive, trauma-informed practices. It calls for a deeper commitment to presence, humility, and accountability, not as add-ons, but as essential to ethical care.

Keywords: cultural competence, clinical bias, kink-affirming care, ethical practice

Clinical Discomfort and Cultural Silence

In a quiet exam room off to the side of an urban private practice, I offered a flyer for a free educational series on Black sexuality. The provider, a Black woman like me, responded with resistance. Her voice dropped; her arms crossed. The openness sensed minutes earlier had disappeared. I hadn't expected to feel so exposed for naming something we both live with. I crossed an invisible line; unspoken but clearly felt.

I apologized, not because I was wrong, but because her discomfort made me shrink. I softened my voice and fell silent, mirroring the behavior many Black patients report when navigating clinical dynamics. Later, I asked myself: why did I soothe the tension? Why did I silence myself in a space meant for care?

She later shared that her sex education had been limited to, “Don’t have sex.” Her story reflected patterns observed in Black religious communities, especially in the rural American South, where conversations about sex are often shaped by silence, moralism, and shame-based messaging (Astatke et al., 2024). These messages persist into adulthood, exams, and clinical silence.

That moment lingered. Two Black women in a seemingly safe space, still struggling to talk. If that's true for us, how much harder must it be for someone without shared cultural shorthand or safety?

If mentioning sex caused that visceral reaction, how might this provider respond to someone from a non-normative community, kink, polyamory, or otherwise? Many clients don't

feel safe being authentic, and that impacts their care. If patients can't speak freely, how can providers truly support them?

The Erasure of Kink and Identity in Care

As a board-certified sex and kink conscious therapist, I see what happens when fear of judgment becomes reality. Clients often withhold information, not because they doubt themselves, but because they've learned that clinical misunderstandings can carry real consequences. There's a persistent misconception defining kink to only be about sex. It's not. Oversimplification breeds misunderstanding and harm.

What I witness in practice echoes what research confirms. Patients continue to share stories marked by silence, retreat, erasure. Their stories identify a pattern and the literature affirms it. Waldura et al. (2016) found that disclosing BDSM practices often led to discomfort or judgment from providers.

These aren't outliers. They reflect a broader pattern: patients conform to avoid provider discomfort. Honesty is traded for safety, a dynamic rooted in colonial medicine and racism (Amster, 2022; Reede et al., 2024; Lowes & Montero, 2018). As Gilman (1985) and Morgan (2005) illustrate, tropes like the Jezebel and the expectation of Sarah Baartman have cast Black sexuality as deviant, shaping discomfort in clinical settings.

Mental and sexual decolonization are often needed before Black patients can disclose. Readiness to speak about sex is shaped by unlearning shame and stigma, an emotional process that also affects seeking or accepting care. The inner work makes space for liberation and expression as well as love in relationships (Stevens-Uninsky et al., 2024).

Jansen et al. (2024) found that BDSM practitioners often hesitate to discuss sexual health due to prior discrimination and mistrust.

When Silence Becomes Harm

The result isn't just awkward; it also threatens health. When people censor themselves, crucial information is missed. Vital screenings are skipped. Symptoms go unreported. Follow-up care falls through. The result? Increased misdiagnoses, untreated conditions, and deepening mistrust. These aren't communication breakdowns; they're systemic failures.

While this essay centers Black patients, the pattern spans identities. Across races, genders, orientations, and abilities, people report similar erasures. The call for dignity, presence, and informed care is universal.

Kink as a Site of Healing and Consent

Kink offers healing, identity, and safety for many. Its foundation, trauma informed boundaries and negotiated consent, aligns with ethical care. As Rahman (2024) explains, acknowledging kink can offer healing, especially when trauma has shaped one's relationship with consent. In her earlier work (2023), she describes kink's role in reclaiming agency and integrating emotional healing. Recognizing these aspects supports respectful, holistic care (Smith, 2022).

Patients shouldn't have to choose between honesty and access, yet many do. Smith (2022) noted that participants felt forced to choose between truth and care when providers didn't understand kink. That choice reflects a deeper failure: the clinical erasure of kink as a valid identity and modality of care.

Tools for Awareness and Unlearning

Implicit bias shapes outcomes in subtle but powerful ways (Blair et al., 2011; Hall et al., 2015; FitzGerald & Hurst, 2017). Providers must remain present, listen without judgment, and engage without retreat. This requires training and unlearning. It calls for examining language, tone, posture, and welcoming correction as part of ethical care.

Tools exist. The Implicit Association Test can reveal unconscious bias (Sukhera et al., 2019; Amodio, 2008). SOAP notes, used reflectively, help providers examine their assumptions and emotional responses (Johnson & Richard-Eaglin, 2020). These are not fixes, but they are entry points.

Despite available tools and research, many providers remain unprepared. This has real health impacts. Policy reform must be co-designed with, not just informed by, marginalized communities. We don't need expanded care; we need care that's complete and accurate.

The Work of Cultural Competence

Cultural competence is a continual practice of humility and listening, not a box needing to be checked off. In my work, clients don't want tolerance, they want to be seen.

Yes, discomfort is real. But responsibility lies with providers and systems. Health equity means creating space for whole identities, kink, pleasure, consent, as essentials, not extras.
Even when systems lag, providers can choose awareness, presence, and accountability, beginning with listening to long-silenced voices. As Morgan (2005) and Gilman (1985) illustrate, the silences surrounding Black sexuality are historically constructed and deeply rooted but aren't irreversible. Disrupting them is where care begins.

Colonial legacies didn't just erode trust, they seeded resistance. In communities once subjected to coercive care, consent is layered with tension (Lowes & Montero, 2018). Let's be clear: change cannot rest solely on patients. Yes, many of us are unlearning shame, reclaiming voice, and restoring bodily sovereignty. That includes the deep work of naming silence and releasing judgment.

Before trust and disclosure can happen, many must first engage in deeper work; the mental and sexual decolonization required to speak freely about their bodies, identities, and desires (Stevens-Uninsky et al., 2024).

Presence Beyond Performance

Healing moves in both directions: systemic change and personal responsibility. Some providers engage from a distance, quoting research, citing texts, but struggle to stay emotionally present in the room. Comprehension is a start, but it isn't enough. True care requires presence in person, in real time, when silence and discomfort fill the space.

Silence doesn't mean disinterest. When patients retreat, it's survival. And presence, not performance, is what opens the door to healing.

That moment didn't stop the work; it clarified where it was most needed. She didn't take the flyer, but that moment offered something else: insight into where healing work remains. Even when information isn't accepted, the invitation matters. It reveals the space between intention and readiness; a space where deeper, more courageous care can begin. And in this work, that kind of clarity is its own offering.

Disclosure Statement

No potential conflict of interest was reported by the author.

References

Amodio, D. M. (2008). The social neuroscience of intergroup relations. *European Review of Social Psychology, 19*(1), 1–54. https://doi.org/10.1080/10463280801927937

Astatke, R. H., Evans, Y. Y., Baker, S., Simpson, M., & Thompson, T. A. (2024). A Miseducation: Perspectives on Sexuality Education from Black Women in the US South. *International Journal of Environmental Research and Public Health*, *21*(11), 1516. https://doi.org/10.3390/ijerph21111516

Blair, I. V., Steiner, J. F., & Havranek, E. P. (2011). Unconscious (implicit) bias and health disparities: Where do we go from here? *The Permanente Journal, 15*(2), 71–78.

Chapman, E. N., Kaatz, A., & Carnes, M. (2013). Physicians and implicit bias: How doctors may unwittingly perpetuate healthcare disparities. *Journal of General Internal Medicine, 28*(11), 1504–1510. https://doi.org/10.1007/s11606-013-2441-1

FitzGerald, C., & Hurst, S. (2017). Implicit bias in healthcare professionals: A systematic review.

BMC Medical Ethics, 18(1), Article 19. https://doi.org/10.1186/s12910-017-0179-8

Gilman, S. L. (1985). *Difference and pathology: Stereotypes of sexuality, race, and madness*. Cornell University Press.

Hall, W. J., Chapman, M. V., Lee, K. M., et al. (2015). Implicit racial/ethnic bias among healthcare professionals and its influence on healthcare outcomes: A systematic review. *American Journal of Public Health, 105*(12), e60–e76. https://doi.org/10.2105/AJPH.2015.302903

Jansen, K. L., Fried, A. L., Goetz, C., & Kang, S. (2024). Mistrust and missed opportunities: BDSM practitioner experiences in healthcare. *The Journal of Sexual Medicine, 21*(11), 1047–1053. https://doi.org/10.1093/jsxmed/tjae015

Johnson, R., & Richard-Eaglin, A. (2020). Combining SOAP notes with guided reflection to address implicit bias in healthcare. *Journal of Nursing Education, 59-59*. https://doi.org/10.3928/01484834-20191220-10

Morgan, K. P. (2005). Gender, sexuality, and the Black body: Historical myths and contemporary realities. In E. Bailey (Ed.), *The color of sex: Whiteness, heterosexuality, and the fictions of white supremacy* (pp. 87–102). Temple University Press.

Rahman, Y. R. (2023). *A power exchange with your pain: A guide towards reconciliation with SELF*. Doc Yu Roc Publishing.

Rahman, Y. R. (2024). *Therapeutic BDSM: An alternative form of healing*. Doc Yu Roc Publishing.

Smith, K. M. (2022). *Coming out kinky: A mixed methods study to inform the design of a health communication campaign promoting disclosure of kink identity to physical healthcare providers* [Doctoral dissertation, University of North Carolina at Chapel Hill]. ProQuest Dissertations Publishing.

Stevens-Uninsky, M., Barkhad, A., MacDonald, T. *et al.* Decolonization in sexual and reproductive health research methods: a scoping review. *BMC Health Serv Res* **24**, 1460 (2024). https://doi.org/10.1186/s12913-024-11817-z

Sukhera, J., Wodzinski, M., Rehman, M., & Gonzalez, C. M. (2019). The Implicit Association Test in health professions education: A meta-narrative review. *Perspectives on Medical Education, 8*(5), 267–275. https://doi.org/10.1007/s40037-019-00539-6

Waldura, J. F., Arora, I., Randall, A. M., Farala, J. P., & Sprott, R. A. (2016). Fifty shades of stigma: Exploring the healthcare experiences of kink-oriented patients. *The Journal of Sexual Medicine, 13*(12), 1918–1929. https://doi.org/10.1016/j.jsxm.2016.09.018