

Exploring the “Bisexual Bridge”: A Qualitative Study of Risk Behavior and Disclosure of Same-Sex Behavior Among Black Bisexual Men

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Black Americans represent 13% of the general population in the United States, but they accounted for 49% of the estimated 56 300 incident HIV infections in 2006.¹ Moreover, among Black Americans, HIV disproportionately affects heterosexual women and men who have sex with men (MSM) much more than it affects other “risk group” categories. Recent media and public health attention has focused on the potential role of Black bisexual men in “bridging” the HIV epidemics between these 2 subpopulations.^{2–7} This “bisexual bridge” theory proposes that heterosexual women are unknowingly put at risk for contracting HIV through sexual contact with bisexual men who covertly have sex with other men. Such men are colloquially described as being “on the down low.”^{2,4,6,7} Empirical research cited in support of this theory has demonstrated conflicting results and is often fraught with sampling and methodological problems such as the assumption that all bisexual men are “secretive,” the inclusion of few Black men in bisexual samples, pooling bisexual men with exclusively homosexual samples, varying temporal definitions of “bisexuality,” and blurring distinctions between bisexual behavior and bisexual identity.^{8–13} Moreover, probability estimates of bisexual behavior among Black men are only 2% to 3%,^{5,14} and recent reviews have noted that few studies have attempted to explore the social determinants of sexual disclosure (to male and female partners) and condom use from the perspective of the men themselves.^{15,16}

Nevertheless, there are no known empirically based theories of sexual behavior among bisexual men. Moreover, the “bisexual bridge” theory contributes to an oversimplification of the underlying processes that shape sexual disclosure and condom use. Instead, the decisional-balance theoretical construct from the Transtheoretical Model and the Stages of Change schema^{17,18} may offer

Objectives. We explored factors influencing sexual behavior, disclosure of same-sex behavior, and condom-use practices among Black bisexual men.

Methods. We conducted semistructured interviews with 38 Black men in Atlanta, Georgia, who reported having had oral, vaginal, or anal sex with both men and women in the prior 6 months.

Results. Participants described approaches to disclosure of same-sex behavior as part of a complex decisional balance influenced by both situational and individual factors and ranging from full disclosure to total secrecy. Influences on sexual behavior and condom-use practices included: (1) type of relationship, (2) gender-specific considerations, (3) perceptions of comfort or trust, and (4) fear of disease or pregnancy.

Conclusions. Disclosure of same-sex behavior was not a major influence on the sexual behavior and condom-use practices of the Black bisexual men in our study, who demonstrated heterogeneity in approaches to sexual behavior, disclosure of same-sex behavior, and condom-use practices. Additional research is needed to assess the social determinants of sexual risk for this population. Future HIV-prevention efforts should include initiatives to encourage accuracy in risk assessment and in taking sexual histories in clinical settings. (*Am J Public Health.* 2010;100:159–164. doi:10.2105/AJPH.2008.158725)

a more useful framework for understanding issues of disclosure and sexual behavior among Black bisexual men. Originally adapted from Janis and Mann’s (1977) decision-making model, this construct posits that many health behaviors result from an individual weighing the relative pros and cons of engaging in that behavior. Thus, this construct challenges the assumption of secrecy; instead, Black bisexual men may engage in a more complex process of weighing the pros and cons of telling female partners of their same-sex behavior, telling their male partners of their sexual behavior with women, or engaging in condom use depending on aspects of the situation, their partner, and the context in which the sexual encounter occurs. Decisional balance has been used to explain many behavioral outcomes, including condom use,¹⁹ but little is known about how it informs understanding of the sexual risk behavior of Black bisexual men.

Recent literature reviews have called for more qualitative research with Black bisexual men to inform future HIV-prevention efforts.^{12,15,16} Qualitative methods are necessary to create in-depth understanding of the social dynamics that may be promoting sexual risk or protective behaviors among this population. The goal of this pilot study was to explore social factors influencing sexual behavior, patterns of disclosure of same-sex behavior to female partners, and condom-use practices with male and female partners among Black bisexual men.

METHODS

We recruited participants utilizing Web sites where men seek sex with other men (e.g., men4now.com, adam4adam.com), phone chat line services, flier distribution at targeted community venues (e.g., barbershops, nightclubs),

and snowball sampling. For Internet recruitment, we created a screen name and profile to advertise for the study, and we actively recruited participants by sending messages to individuals whose screen names were listed as “online” when researchers were logged into the Web site. Participants were eligible if they: (1) self-identified as Black or African American, (2) were aged between 18 and 45 years, (3) currently resided in the Atlanta metropolitan area, and (4) reported having had oral, vaginal, or anal sex with both a man and a woman in the prior 6 months.

Data Collection

The interviewers (2 Black men) conducted 38 face-to-face audio-recorded interviews in a private conference room located in the lead investigator’s office building. Before beginning the interview, the interviewers verbally reviewed an information sheet with each participant describing the nature of the study and its risks and benefits. All interviews took from 60 to 120 minutes. After interview completion, each participant received \$50 compensation and 5 business-sized cards with study information to distribute to individuals in their social and sexual networks.

Measures

The semistructured interview guide included questions designed to explore patterns of sexual behavior, disclosure of same-sex behavior, and condom-use practices. Using previous research as a basis, we created the following domains for the interview guide: (1) racial experiences and identification; (2) religious beliefs; (3) perceived gender-role norms and expectations; (4) beliefs about relationships, sexuality, and sexuality labels; (5) patterns of disclosure of same-sex behavior in general and in intimate relationships; (6) sexual behavior and condom use with male and female sexual partners; (7) HIV beliefs and personal risk perception; and (8) HIV-testing practices and beliefs. The semistructured format allowed participants to respond freely and answer questions in an open-ended way.

At the end of the interview, participants completed a brief demographic questionnaire containing questions on age, reported sexual identity, income, and HIV status.

Data Analysis

All interviews were digitally recorded, transcribed, and uploaded into NVivo 7 (QSR International, Cambridge, MA), a qualitative management and analysis software package. Research staff developed a coding workbook based on the sections of the interview guide, and we targeted 3 primary domains—patterns of disclosure of same-sex behavior, sexual behavior and condom use with male and female sexual partners, and HIV beliefs and personal risk perception—to identify the most common themes in the initial 3 interviews. We compared coding patterns to ensure adequate intercoder agreement.²⁰

The remaining 35 interviews were split between research staff (who worked in teams of 2) and coded in a similar fashion. Then we carefully read all the text in the coded segments and generated notes highlighting connections with categories and subcategories from the first coding phase. Finally, we compiled quotations from participants included under the codes within the 3 domains described above, and we developed concepts and relationships pertinent to these core themes. In accordance with true qualitative methodology, quantitative descriptions of how many participants expressed each theme are not detailed, as the overall goal of the study was to explore the rich narratives emerging from their interviews.²¹

RESULTS

Participants were 38 Black men residing in Atlanta, Georgia, who reported having had oral, vaginal, or anal sex with both a man and a woman in the prior 6 months. Fifty percent (19) reported being aged 18 to 29 years, and the remaining half reported being aged 30 to 45 years. Thirty-seven percent (14) reported being HIV-positive, and 63% (24) reported being HIV-negative or not knowing their HIV status. All of the participants self-identified as either heterosexual or bisexual, and self-reports of individual yearly income ranged from less than \$15 000 to \$60 000.

We identified 3 major themes in the participants’ interview comments: (1) the broad continuum of disclosures of same-sex behavior, (2) relationship dynamics and perceptions influencing sexual behavior, and (3) condom-use practices based on risk perception and fear.

Broad Continuum of Disclosure of Same-Sex Behavior

Participants described a continuum of disclosure of same-sex behavior to sexual partners, family members, or coworkers, which included: (1) full disclosure, (2) conscious omission of information, or (3) total secrecy. Disclosure of same-sex behavior was largely influenced by either the situational context (e.g., work, family, relationship) or individual sexual-partner considerations (e.g., gender, perceived trust, history with the other person).

Full disclosure. Some participants reported full disclosure to both male and female sexual partners for moral reasons or just to be honest:

I tell anybody that I’m having sex with whatever they want to know. No secrets. (participant 7)

I always explain to them [sexual partners] that I like both [men and women], but I never deal with both at the same time because I feel like that’s just wrong. (participant 15)

I think the most important thing is honesty, and I’m going to be honest and let you know I’m bisexual. I’m also attracted to men, but seeing that I’m faithful in every relationship I’ve ever been in, you have nothing to worry about. (participant 4)

Others stated that full disclosure depended on the degree of intimacy with a partner, the situational setting, or perceived stigma from a family member:

If I had to tell someone, it would be my girlfriend, who I’m laying down in the bed with every night . . . having unprotected sex with. Even though I’m having protected sex with everybody else, if someone needed to know, she would be the first. (participant 25)

To me personally, for health care reasons, it’s my health care provider. You know. Other than that . . . I don’t see why it’s an issue with anybody else. (participant 11)

My youngest sister, I lie to, because, see, she’s more judgmental. She would look at it [homosexuality] in a different way; she would think that she can’t have my nephews around me. But my oldest sister, she wouldn’t love me any less. (participant 16)

Conscious omission of information. Some men would not actively disclose same-sex behavior to women unless asked, a practice that some justified by citing women’s lack of openness about their own previous sexual behavior:

Participant 10: People are very secretive these days. I mean, if a chick asked me and I felt comfortable talking to her . . . “Have you ever got

head [received oral sex] from another guy?" I probably would tell her, "Yeah, I've done it."

Interviewer: Why don't they [female sexual partners] need to know?

Participant 1: Do she only tell or share how many guys she done fucked and what she did with them? I mean, how many dick she done sucked? I ain't the first dick you sucked, so, I mean, you ain't tell me that. So it goes both ways, dude.

Total secrecy. All participants agreed that coworkers did not need to know "their business," and nondisclosure to female sexual partners was sometimes rationalized on the basis of consistent condom use:

I personally don't think that it's any of their [female sexual partners'] business. I don't think that a person should just be openly telling people about their sex life. Yeah, you are putting that other person's life on the line, but if you're totally safe with both sexes, then, you know what I'm saying, it's nothing to explain or talk about. (participant 3)

Although some participants approached disclosure to family members on a case-by-case basis, others felt strongly that the risk of stigma was too great to discuss with family:

Interviewer: Have you ever told close family members or friends about your sexuality?

Participant 27: No. I wouldn't do that. That would be like digging your own grave.

The most commonly cited reason why participants engaged in total secrecy was stigma—fear of losing family members, community status, their jobs, or female sexual partners because of pejorative stereotypes of same-sex behavior. One participant was even fearful that disclosure could lead to physical violence:

Interviewer: What would be the pros and cons of you telling people in your workplace?

Participant 16: Same thing: hate! Stereotype! Stereotype! You never know, man. You can get killed over some shit like that, man, stupid shit.

Relationship Dynamics and Perceptions Influencing Sexual Behavior

The type of relationship. For some, what they would do sexually and how quickly they would have sex with someone depended on a certain level of trust and intimacy, primarily with main female sexual partners:

How do I decide what I'm willing to do with a woman? It's easy because my old lady, she can get—we can whatever. We have no boundaries on our sex life, so we already been together for two years. An outside female, I'm not trying to really get no feelings involved or get her attached to me. (participant 25)

I feel that my sex is precious, you know what I'm saying? When I have sex, I want it to be with somebody I'm feeling, or somebody that's feeling me, you know what I'm saying? I really just want somebody to be there for me. (participant 15)

The relationship "vibe." Other participants described an ambiguous "vibe" or "flow" as the main determinant of what they would feel comfortable doing sexually:

Interviewer: How do you decide what you are going to do sexually with women—anal or vaginal?

Participant 1: How do I decide? I just go with the flow. Just go with the flow.

Interviewer: So how do you decide what you're willing to do with a man?

Participant 29: It's just depending on the vibe, you know what I'm saying? It depends on how some men carry themselves.

When asked to elaborate on what a particular "vibe" or "flow" meant, many had trouble specifically defining their meanings, but they used the terms equally to describe perceived level of comfort with both male and female sexual partners.

Trust. Trust also emerged as an important influence of sexual behaviors. By "trust," participants meant they felt comfortable that: (1) a male or female sexual partner would not be a high risk for a sexually transmitted infection, (2) a male sexual partner would not tell other people that the participant was having sex with men, and (3) general respect for privacy was assured. Some men declared that "I don't have sex unless I'm in a relationship" (participant 4), whereas others felt that certain sexual behaviors reflected more of an emotional attachment than just sex.

Gender-specific considerations. The majority of participants reported engaging only in receptive oral sex or insertive anal sex (being the "top") with other men, citing reasons ranging from pain (receptive anal sex "hurts") to perceptions that others would consider them more "submissive" or "gay" if they engaged in receptive anal sex. Those who reported engaging in receptive anal sex did so in the context of a committed relationship or with the aid of alcohol or drugs: "If I'm high, I'm versatile; if I'm sober, I'm top" (participant 17). Additionally, several participants described variations of monetary exchange for sex with other men. These transactions could be part of "hustling" to make ends meet, or they could be the beginning of something more intimate:

I think money has been a key to me doing a lot of gay shit. (participant 16)

Interviewer: So were you attracted to men, or were you doing it for the money?

Participant 13: Basically doing it for the money, and then I started getting sexually attracted to them later on. Not deeply, but feeling like, you know, a man could be there for another man if the man is really going through something. Like someone to talk to.

The most commonly cited influence on sexual behavior decisions with women was hygiene and cleanliness, often assessed on the basis of whether she "smelled right" or appeared "clean" (participant 10). Interestingly, this consideration was not mentioned when describing sexual interactions with men.

Condom-Use Practices Based on Perceived Risk and Fear

All participants demonstrated knowledge about specific high-risk behaviors for HIV (anal or vaginal sex without a condom) and said they were the primary initiators of condom use with both male and female sexual partners. Moreover, they stressed the personal importance of HIV in their lives because of knowing friends and family living with HIV, which appeared to facilitate their perception of personal risk and decisions to use condoms:

I don't want to leave this world that way. It's a long, slow death, and I don't want to leave the world that way. (participant 20)

It's [HIV] very important. I don't want to be that sole family member or that one family member in my family to die from HIV, because it's a preventable disease, and I don't want to bring that stress and crying and all that stuff. . . . I don't want to bring that to my family, so I have to protect myself. (participant 3)

When asked whether sex with a man or sex with a woman was more likely to expose them (or to have exposed them) to HIV, most said they believed they could contract HIV from either gender equally. However, a few participants felt that men were inherently "riskier" than women, for a variety of underlying reasons. For instance, some men described themselves as simply being "more inclined" not to use condoms with women because they thought women were less likely to have HIV (participant 24). Others perceived sex with other men as more "risky" for HIV transmission because they thought men were inherently

more sexually “promiscuous” than women (participant 16). Even when describing female sexual partners as more “risky,” participants did so within the context of their behavior with “down low” bisexual men:

Interviewer: Why do you think you would get more HIV from women?

Participant 4: Because those men are DL [down low], and so, like, they are sleeping with these women, and he's having unprotected sex with men and then coming back to his girlfriend and having sex with her.

It is unclear whether participants' assumptions about the HIV risk of sex with men were based on continued perceptions of HIV as a “gay” disease, perceptions of men as more promiscuous as women, personal sexual experiences, or a combination of all these factors. Regardless, even when participants acknowledged that “everybody is suspect” (participant 1) and “you taking a chance for anything when you lay down with anyone, regardless of male or female” (participant 29), some demonstrated a disconnect between this knowledge and personal condom-use practices:

After I get in my mind that I know this person, you know, and the wise thing should be just because you know that person, it doesn't mean that that person might not have anything. Sometimes I get into the point of where, hell, I just want to, even if it sounds stupid, but you know, you're doing something risky, but hey, you know, if something happens, it's like, hell, we'll find out what happens afterwards. . . . I'll do the test or something. And fortunately, things have been alright. (participant 18)

Many participants perceived their personal HIV risk as “low” or “none” because “I always use a condom” (participant 14), whereas others rationalized risky behavioral choices with statements such as “I know my body” (participant 15) or justifications such as consistent condom-use practices, low risk assessment of sexual partners based on a “vibe,” or perceived comfort after being with the same partner for a prolonged period of time.

Fears of sexually transmitted diseases and of causing an unintended pregnancy were both cited as the main incentives for consistently using condoms with men and women:

Interviewer: What helps you use condoms consistently?

Participant 26: Contracting a disease. I ain't trying to get shit, and I ain't trying to give my wife

shit. You can use a condom or you can risk getting a disease, you know what I'm saying?

Interviewer: How often do you have unprotected sex with women?

Participant 4: Never. Not only do I have a risk of catching HIV and STD but being their baby daddy? Uh-uh. No! No chance in hell.

Finally, participants reported larger situational factors influencing decreased condom use, such as being “caught up in the moment” (participant 15), “if I'm drunk” (participant 19), or only after trust and mutual testing has been established:

I would always use a condom with a woman, but as far as a guy, because a guy can't get pregnant. But I mean if we are both okay, and we got tested and both are clean, and after a certain amount of time, I would say a year, and trust has been built and we trust each other and we just know that we'll be faithful to each other and not go out and do nothing crazy, I wouldn't use condoms. (participant 38)

DISCUSSION

Our findings suggest that the decisional balance theoretical construct offers a useful mechanism for understanding sexual disclosure and condom-use practices, particularly considering the heterogeneity in responses from this sample of Black bisexual men.¹⁷ Disclosing same-sex or bisexual behavior entailed weighing the relative pros and cons, considering the gains and costs to self and others, and considering the approval or disapproval from others that may result from disclosure. Although this is not surprising, it does contradict the often sensationalistic and simplistic portrayals of nondisclosure in the media as a simply mindless, reckless, and immoral action.^{4,6,7}

Indeed, the men in this sample made same-sex disclosure decisions as the result of a much more nuanced, fluid decision-making process, and same-sex behavior was not always characterized by secrecy. These findings suggest that future research with this population should more richly explore the circumstances in which disclosure of same-sex behavior occurs. Moreover, generalized public health messages that encourage people to fully disclose same-sex behavior without weighing the potential positive consequences (e.g., increased self-respect as a result of being honest) against the potential negative consequences (e.g., loss of relationship with loved ones, ostracism, physical harm)

may not apply to all bisexually active men, particularly those already engaging in consistent condom-use practices.

Nondisclosure of same-sex behavior to female sexual partners was common among the men in our sample, but did not appear to influence decisions to not use condoms with their male sexual partners. This finding complements previous quantitative research among Black MSM demonstrating significant associations between disclosure of same-sex behavior and higher rates of unprotected anal intercourse with other men.^{8,22} However, the men described a variety of individual considerations (e.g., fear, perceptions of personal risk), interpersonal considerations (e.g., relationship characteristics, trust), and situational considerations (e.g., whether drugs or alcohol were involved) that informed their condom-use practices. These results are similar to previous qualitative research describing substance use as “allowing” or “facilitating” comfort with same-sex behavior and risk-taking among Black bisexual men, and to research exploring broader determinants of condom use described among probability samples of US men and women.^{23,24}

Although Black bisexual men may have unique social circumstances, given their sexual relationships with both men and women, the factors influencing their condom-use practices may be more complicated than binary notions of disclosure of same-sex behavior, and these factors may in fact be more similar to those operative among the general population. Our findings highlight the need for future research with currently bisexually active men to reexamine and quantitatively test the tacit assumption that disclosure of same-sex behavior to women and safer sex practices are inextricably linked, giving equal consideration to additional social and structural factors.

Among Latino men who either (1) self-identified as bisexual but only engaged in homosexual behavior, (2) reported no sexual identity but had sex with both men and women, or (3) reported both bisexual behavior and bisexual identity, merely reporting sex with a woman increased the likelihood of engaging in unprotected anal intercourse with men, regardless of self-reported sexual identity.²⁵ Previous work with Black bisexual men, however, has found that they are no more likely to engage in unprotected anal intercourse with men than

their White bisexual or Black homosexual counterparts.^{5,12,14,26–28} Sex with women may not be a sole predictor of Black bisexual men's condom use with their male partners; rather, condom use may be influenced by the type of relationship with both male and female partners (steady versus casual), sexual networks, age differences between partners, or a perceived “vibe” and level of trust, among others.^{29,30} Moreover, our sample described a variety of additional considerations for condom-use practices, including but not limited to fear of pregnancy or disease, being in the “heat of the moment,” or being “drunk” or “high,” all of which were previously identified as factors influencing condom-use practices among a sample of Black bisexual men in New York City.²⁹ Hence, bisexual behavior itself may not inherently put Black men at higher risk for HIV than their exclusively heterosexual or homosexual counterparts; rather, the risk may stem from additional considerations that apply to all sexually active Black men.

Our findings suggest that any “bridging” of HIV and sexually transmitted diseases between Black MSM and Black heterosexual women via Black bisexual men may be: (1) bidirectional, given the varying disclosure patterns and condom-use practices Black bisexual men display with both their male and female sexual partners; (2) influenced by mental health and substance abuse considerations; and (3) the result of a disconnect between the men's described level of HIV risk knowledge and the relative safety of their actual sex practices. This disconnect has been previously described among Black MSM,³¹ highlighting the need for additional research to ascertain the pathways through which Black men translate fundamental HIV knowledge into individual behavioral choices, particularly in the face of larger structural forces (poverty, racism, sexual prejudice), “intangible” variables (love, trust, or “vibe”), and gender-specific stereotypes (perceptions of sex with men as only for monetary exchange or “just sex,” and the potentially misogynistic emphasis on women's “cleanliness” or “hygiene”).

Finally, our findings confirm the importance of detailed sexual behavioral assessments by medical providers screening for HIV and sexually transmitted diseases among Black men, given the high discordance between sexual behaviors and reported sexual

identification labels among men in clinical settings.^{32,33} Research has found that disclosure of same-sex behavior to medical providers by Black MSM in clinical settings is associated with higher rates of HIV testing, but this finding may be mediated by accurate perceptions of “risky” sexual behavior, and we have little information on similar considerations for Black bisexual men.³⁴ Moreover, honest sexual disclosure among Black men in clinical settings should be encouraged not solely pertaining to their same-sex behavior but also when obtaining accurate assessments of sexual risk in their relationships with their female sexual partners, given previous research noting sexual concurrency as a driving force behind the racial disparity in HIV among US heterosexuals.³⁵ Medical settings may represent a useful location for routinized screening of sexual behavioral risks and for prevention initiatives for both HIV-negative and HIV-positive bisexual men.³⁶ Given the diversity of lived experiences of bisexual behavior among the men in our sample, prioritizing targeted sexual behavioral screening and routinized HIV testing in clinical settings may help identify new cases of HIV and link patients to primary care services.^{37–39}

Limitations

This study has some limitations. First, both disclosure of same-sex behavior and unprotected sex remain highly stigmatized in the United States, thus increasing the likelihood of social desirability bias among our participants' responses. Second, our analysis focused on general themes relevant to the entire sample and does not reflect intrasample comparisons (according to HIV status or age category). Third, the interviewers did not self-identify as any particular sexual orientation; thus, participant responses may have been influenced by their perceptions of interviewers' sexual orientations and participants' subsequent level of comfort. Fourth, although our recruitment methods (Internet, phone chat line, snowball) were likely able to obtain bisexual men who did not attend gay-identified venues, bias may have resulted from any inability to reach varied “subpopulations” of bisexually active men according to varying levels of secrecy. Finally, we used convenience sampling, which does not facilitate the generalization of study findings to a larger population of Black bisexual men.

Despite these limitations, our findings fill an existing gap in the HIV literature describing determinants of disclosure of same-sex behavior and condom-use practices among Black bisexual men.

Conclusions

Given the stigma associated with bisexuality and the diversity in Black bisexual men's approaches to sexual behavior, disclosure of same-sex behavior, and condom-use practices, Black bisexual men may not only be a difficult population to define using traditional identification reporting methods; they may also represent a challenging target population for specific HIV-prevention efforts. The results of this study have implications for future HIV research initiatives and prevention interventions among Black bisexual men. Such efforts should further explore and assess the social determinants of protective and risk behavior, as well as subsequent implications for clinical outcomes in this population. However, this work should target currently bisexually active Black men, and it should include both qualitative and quantitative research efforts as well as increased consideration of HIV behavioral screening and testing initiatives in clinical settings. Black bisexual men may represent a more heterogeneous population than many have estimated, and our future research and intervention efforts with this population should seek to assess sexual risk and encourage safer sex practices beyond emphasizing disclosure of same-sex behavior alone. ■

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D.J. Malebranche co-originated the study, participated in all aspects of data collection, helped develop the coding and sampling scheme, supervised the acquisition of data, analyzed and interpreted the data, and led the writing for all drafts of the article. K.J. Arriola co-originated the study, guided development of the coding and sampling scheme, analyzed and interpreted data, and reviewed and revised drafts of the article. T.R. Jenkins and E. Dauria assisted with coding, analyzing, and interpreting data, and they reviewed and revised drafts of the article. S.N. Patel reviewed and revised drafts of the article.

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Human Participant Protection

The research protocol was approved by Emory University's institutional review board.

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