



RELIGIOUS BEHAVIOUR OF LGBT COMMUNITIES IN CENTRAL LOMBOK REGENCY, WEST NUSA TENGGARA: AN EXTENDED QUALITATIVE STUDY OF RELIGIOUS PRACTICE, STIGMA, ADAPTATION AND SOCIAL PERCEPTION

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Abstract

This research is motivated by the dynamics of religious life within the LGBT community in Central Lombok Regency, which exists in a conservative Muslim society that adheres strongly to Islamic norms. In this context, the LGBT community often faces social pressure, theological stigma, and exclusion from mainstream religious institutions, which encourages them to develop more private, hidden, and adaptive patterns of religious expression. This study aims to understand how the LGBT community shapes their patterns of religious behaviour under social-religious pressure, as well as how these patterns impact local societal perceptions. Theoretically, this study uses a Community Behaviour and Central Behaviour approach, as well as the stigma and labelling theory framework from Erving Goffman and Howard Becker. The methodology used is qualitative with data collection techniques through in-depth interviews, participatory observation, and documentation studies of LGBT community members in Central Lombok. The research results indicate that the religious patterns of the LGBT community are contextual and transformative. Despite facing exclusion, they continue to practice religious activities such as prayer, fasting, and reading the Qur'an, although these are mostly carried out in private spaces or within inclusive communities. The findings also reveal a social ambivalence: some members of society show empathy towards the spirituality of the LGBT community, while the majority still view them as a moral and social threat. In addition, the reality of sexually transmitted infections (STIs) arising from certain risky behaviours is also a significant concern that demands an educational and preventive approach based on religious values and public health.

Keywords *LGBT, Religiosity, Stigma, Community Behaviour, Central Behaviour*

INTRODUCTION

This research is motivated by the complex dynamics of religious life experienced by lesbian, gay, bisexual, and transgender (LGBT) community members in Central Lombok Regency, West Nusa Tenggara. The issue cannot be reduced to a debate about sexual orientation or gender identity alone because it is simultaneously connected with religion, family, community morality, social identity, public stigma, and access to religious institutions. In a predominantly Muslim environment in which Islamic norms occupy an important position in everyday social life, religious identity becomes a significant component of social belonging. Consequently, individuals whose sexual orientation, gender identity, or gender expression is perceived as inconsistent with dominant expectations may experience tension between personal spirituality and the social expectations attached to religious membership (Durkheim, 1912/1995; Geertz, 1973). (Berger, 1967; Geertz, 1973)

The social context of Central Lombok is especially important because religion is embedded in kinship, village life, educational institutions, communal ceremonies, and

public morality. Religious norms do not operate only as abstract theological propositions; they are translated into expectations concerning family formation, gender roles, modesty, sexuality, and appropriate social behaviour. In such circumstances, the label LGBT may become a condensed social category through which a person's morality, religiosity, and social worth are evaluated. Labelling can therefore transform an individual difference into a public identity that influences interaction, access to social networks, and perceived legitimacy (Becker, 1963; Goffman, 1963).

Previous scholarship has shown that religious life among sexual and gender minorities is neither uniformly secular nor uniformly opposed to religion. Individuals may retain strong religious beliefs while simultaneously negotiating identities that are contested by their religious communities (Yip, 1997; Gross & Yip, 2010). The central question, therefore, is not simply whether LGBT individuals are religious, but how religious commitment is reorganized when institutional belonging is uncertain. This research approaches religiosity as an active social process involving interpretation, adaptation, concealment, negotiation, and the search for spiritually safe spaces.

The study is also grounded in the recognition that stigma is not merely an individual feeling. Stigma operates through social classification and institutional practices. Goffman (1963) explains stigma as a discrediting attribute that changes the way a person is socially perceived, while Becker (1963) emphasizes the role of social reaction in producing deviance. Applied to religious life, these perspectives help explain why some respondents prefer to worship privately, avoid particular religious spaces, or disclose aspects of their identity selectively. Such practices should not automatically be interpreted as religious withdrawal; they may constitute strategies for preserving both faith and personal safety. (Goffman, 1959; Jenkins, 2008).

The principal problem addressed by this study is the apparent contradiction between continued religious commitment and restricted public religious expression among some LGBT community members in Central Lombok. The contradiction becomes visible when individuals continue prayer, fasting, Qur'anic reading, remembrance, or other devotional activities but limit their visibility within mainstream religious settings. This phenomenon raises sociological questions concerning how religious behaviour is formed when a person simultaneously participates in a religious culture and experiences exclusion from some of its institutions (Glock & Stark, 1965; Stark & Finke, 2000).

The study consequently seeks to understand three interconnected dimensions. First, it examines how LGBT community members construct and practise religious behaviour under social and theological pressure. Second, it investigates how stigma and labelling influence the location, visibility, frequency, and form of religious practice. Third, it explores how these patterns are interpreted by the surrounding community and how public perceptions, in turn, affect the respondents' religious adaptation. The study thus places individual spirituality within a wider field of social interaction rather than treating religious behaviour as an isolated psychological variable. (Bandura, 1977; Berger & Luckmann, 1966).

The objectives are analytical as well as descriptive. Descriptively, the research identifies forms of belief, worship, religious knowledge, spiritual experience, and moral

consequence. Analytically, it explains why these dimensions may be expressed differently in public and private settings. The study also seeks to identify the mechanisms through which respondents manage disclosure, construct supportive networks, and negotiate their relationship with family, neighbours, religious leaders, and community institutions. This orientation follows the argument that religious behaviour is produced through interaction between personal meaning and social structure (Berger, 1967; Parsons, 1951). (Tajfel & Turner, 1986; Jenkins, 2008).

The theoretical framework combines Community Behaviour and Central Behaviour approaches with stigma and labelling theory. Community Behaviour is used to examine the influence of collective norms, social sanctions, neighbourhood expectations, and institutional environments on individual conduct. Central Behaviour, by contrast, directs attention to internal processes such as personal motivation, religious experience, self-understanding, and meaning-making. The combination allows the research to avoid a false opposition between social structure and individual agency. Behaviour emerges from their continuing interaction (Bandura, 1977; Berger & Luckmann, 1966). (Pargament, 1997; Mahoney, 2010).

Glock and Stark's multidimensional model provides a further analytical instrument. Their framework distinguishes dimensions of religious belief, practice, experience, knowledge, and consequences (Glock & Stark, 1965). In the present study, the model is not treated as a rigid measurement scale. Instead, it is used as a qualitative lens for examining whether respondents maintain belief while modifying practice, retain religious knowledge while experiencing institutional distance, or describe intense spiritual experiences despite social exclusion. This is particularly useful because religiosity cannot be adequately measured by public participation alone. (Rodriguez & Ouellette, 2000; Kubicek et al., 2009).

Stigma theory explains the social consequences of being categorised as LGBT within a conservative religious setting. Goffman's distinction between virtual and actual social identity is relevant because community members may be evaluated on the basis of an assumed identity before their personal religious commitments are known (Goffman, 1963). Labelling theory complements this perspective by showing how social reactions can produce a durable deviant status (Becker, 1963). The two theories help explain why some respondents manage information strategically and why religious practice may move from frontstage to backstage contexts. (World Health Organization, 2022; Creswell & Poth, 2018).

The dramaturgical perspective is particularly helpful in interpreting this movement. Goffman's (1959) distinction between frontstage and backstage behaviour suggests that individuals may perform socially expected roles in public while maintaining different forms of self-expression in private. In this research, however, the concept is used cautiously: private religious practice should not be presumed to be insincere. Rather, it can be understood as an adaptive arrangement that allows respondents to preserve religious meaning while reducing exposure to stigma. Identity management thus becomes a form of everyday negotiation rather than a simple act of deception. (Berger, 1967; Geertz, 1973).

Religious Behaviour as a Multidimensional Process

The findings indicate that respondents' religious behaviour is contextual and transformative. Many respondents continue to identify with Islam and maintain devotional activities despite experiencing tension with dominant interpretations of sexuality and gender. Prayer, fasting, Qur'anic reading, personal supplication, remembrance, and other religious activities remain meaningful sources of spiritual orientation. This supports scholarship suggesting that marginalised individuals can maintain substantial religious commitment even when their relationship with religious institutions is ambivalent (Yip, 1997; Kubicek et al., 2009). (Becker, 1963; Goffman, 1963).

The belief dimension appears in respondents' continued acknowledgement of God, revelation, prayer, moral accountability, and the significance of religious teaching. Their religious identity is therefore not necessarily displaced by LGBT identity. Instead, some respondents negotiate two categories that they experience as socially incompatible. This process resembles broader discussions of multiple and intersecting identities, in which people selectively foreground particular identities depending on context (Tajfel & Turner, 1986; Jenkins, 2008). (Yip, 1997; Gross & Yip, 2010).

The practice dimension is characterised by variation in visibility. Some respondents practise individually at home or in other private places, whereas others participate in religious activities with trusted friends or small communities. Reduced participation in mosques or public religious gatherings should therefore be interpreted in relation to perceived safety, anticipated judgement, and previous experiences of exclusion. Religious practice becomes spatially differentiated: public visibility is reduced while private devotion can remain strong. (Goffman, 1959; Jenkins, 2008).

The experience dimension demonstrates that spirituality may be experienced as a personal refuge. Respondents describe religious activities as sources of calm, moral orientation, hope, and connection with God. This finding is significant because it challenges assumptions that marginalised sexual and gender minorities necessarily experience religion only as oppression. Religion can operate simultaneously as a source of stigma and as a source of resilience, depending on the social context in which it is encountered (Pargament, 1997; Mahoney, 2010). (Glock & Stark, 1965; Stark & Finke, 2000).

Private Religion, Adaptation, and Inclusive Spaces

One of the most important patterns is the relocation of religious expression from highly visible institutional spaces to private or semi-private settings. This relocation can be interpreted as an adaptive strategy. Where public participation carries a high risk of ridicule, rejection, or exposure, private worship reduces social cost while preserving spiritual continuity. Similar patterns have been identified in research on religious minorities and sexual minorities, where individuals develop alternative networks or selective forms of participation (Gross & Yip, 2010; Rodriguez & Ouellette, 2000). (Bandura, 1977; Berger & Luckmann, 1966).

The emergence of small trusted groups is another form of adaptation. Such groups may not constitute formal religious institutions, yet they can provide companionship, moral discussion, mutual encouragement, and a sense of belonging. The significance of these networks lies in their ability to transform religion from a potentially threatening public institution into an intimate social resource. In sociological terms, they create a micro-level religious environment in which participants can negotiate identity without continuously defending themselves against public suspicion. (Tajfel & Turner, 1986; Jenkins, 2008).

This adaptation also demonstrates that religious behaviour is dynamic. A respondent who avoids a mosque does not necessarily abandon Islam. The same person may intensify private prayer or Qur'anic reading. Likewise, an individual who limits disclosure may still seek religious knowledge through books, digital media, trusted teachers, or informal discussion. Such behaviour illustrates the difference between institutional participation and personal religiosity. The distinction is important for empirical research because conventional indicators of religiosity may underestimate the religious life of stigmatised populations (Glock & Stark, 1965; Stark & Finke, 2000). (Pargament, 1997; Mahoney, 2010).

Social Identity and Identity Negotiation

Social Identity Theory provides a framework for understanding the negotiation between religious identity and LGBT identity. Tajfel and Turner (1986) argue that individuals derive part of their self-concept from social group membership. In the present context, respondents may simultaneously identify with Islam, family, village, occupation, friendship networks, and LGBT-related communities. These memberships do not always carry equal salience. Their relative importance changes according to situation and anticipated social reaction. (Rodriguez & Ouellette, 2000; Kubicek et al., 2009).

Identity negotiation becomes particularly visible when respondents interact with religious institutions. A person may foreground Muslim identity in one context while concealing sexual orientation or gender identity, and foreground LGBT community membership in another context while keeping religious affiliation private. This selective disclosure does not necessarily indicate identity fragmentation. It can be understood as a practical strategy for managing multiple social expectations. Jenkins (2008) notes that identity is produced through the relationship between self-identification and external categorisation; this relationship is central to the experiences described by respondents. (World Health Organization, 2022; Creswell & Poth, 2018).

The research also identifies the importance of recognition. When respondents encounter a person who listens without immediate condemnation, the interaction may strengthen their willingness to discuss religion. Conversely, repeated moral labelling can encourage withdrawal. Recognition therefore functions as a social resource. It does not require agreement on every theological question; rather, it creates conditions in which dialogue remains possible. This distinction is important for public policy because respectful communication can coexist with religious disagreement. (Berger, 1967; Geertz, 1973).

Stigma and Labelling in Religious Life

Stigma appears in several interconnected forms: moral judgement, social distancing, stereotyping, gossip, fear of contamination of children or youth, and assumptions that LGBT identity represents rejection of religion. Goffman (1963) conceptualises stigma as a social process that reduces a person from a whole individual to a discredited attribute. In the Central Lombok context, the LGBT label may become so dominant that respondents' other identities—such as family member, worker, neighbour, or religious believer—are overshadowed. (Becker, 1963; Goffman, 1963).

Labelling theory further clarifies how deviance is socially constructed. Becker (1963) argues that deviance is not simply an inherent quality of an act but is related to the application of rules and sanctions. This does not imply that every community judgement is identical, nor does it require denying religious teachings that respondents or community members consider authoritative. Rather, it directs attention to the social consequences of applying labels: who is labelled, by whom, in what context, and with what consequences for everyday interaction. (Yip, 1997; Gross & Yip, 2010).

Stigma also affects religious participation indirectly. If a respondent anticipates being watched, mocked, or discussed, participation in public worship may become psychologically costly. Avoidance then becomes a rational adaptation to social conditions. The resulting absence from religious institutions can subsequently be interpreted by others as proof of irreligiosity, creating a circular process: stigma produces withdrawal, withdrawal is interpreted negatively, and the negative interpretation reinforces stigma. Breaking this cycle requires more nuanced recognition of hidden or private religious practice. (Goffman, 1959; Jenkins, 2008).

Community Perceptions and Social Ambivalence Isian setelah

The study finds a pronounced social ambivalence. Some members of the surrounding community distinguish between disagreement with LGBT behaviour and recognition of the person's humanity and spiritual capacity. Others remain strongly concerned that LGBT identity represents moral and social danger. These positions should not be reduced to a simple binary of tolerance versus intolerance. They form a continuum shaped by religious interpretation, personal experience, family concerns, social norms, and exposure to public discourse. (Glock & Stark, 1965; Stark & Finke, 2000)

Empathy becomes visible when community members acknowledge that LGBT persons can pray, fast, feel remorse, seek God, and desire moral improvement. Such recognition creates a possibility for dialogue. Yet empathy may coexist with rejection of LGBT identity. This ambivalence is sociologically significant because it shows that religious and moral boundaries can remain firm while interpersonal attitudes become more compassionate. The distinction between theological evaluation and social treatment should therefore be maintained in both research and policy discussions. (Bandura, 1977; Berger & Luckmann, 1966).

The majority perception reported in the study continues to frame LGBT identity as a moral and social threat. Such framing can be strengthened by media narratives, selective religious discourse, rumours, and concerns about children and family stability. Moral panic literature warns that social groups can become symbolic representations of broader

anxieties (Cohen, 1972). In this case, LGBT persons may be discussed not as diverse individuals but as a generalised threat category. Qualitative research is useful for disrupting this generalisation by presenting the complexity of lived experience. (Tajfel & Turner, 1986; Jenkins, 2008).

Sexual Health, STI Risk, and Preventive Education

The research also identifies sexually transmitted infections (STIs) as a public-health concern associated with certain risky sexual behaviours. This issue requires careful treatment because health risks should not be used as evidence that LGBT identity itself causes disease. STI transmission is associated with specific sexual practices, exposure, prevention, testing, treatment, and access to health information. A scientifically and ethically appropriate approach therefore distinguishes identity from behaviour and focuses prevention on modifiable risk factors. (Pargament, 1997; Mahoney, 2010).

From a public-health perspective, prevention should include accurate information, accessible testing, early treatment, partner notification where appropriate, and reduction of barriers to health services. The World Health Organization emphasises comprehensive sexual-health approaches that promote access to information and health services while reducing stigma (World Health Organization, 2022). Stigma itself can become a health risk when fear of disclosure discourages people from seeking testing or treatment. (Rodriguez & Ouellette, 2000; Kubicek et al., 2009).

In a religiously oriented community, preventive education can be connected with values of responsibility, protection of life, cleanliness, self-control, and care for others. Such an approach does not require the research to settle every theological disagreement concerning sexual ethics. Instead, it creates a practical area of shared concern: preventing disease, reducing avoidable harm, and encouraging responsible health-seeking behaviour. This is especially important because moral condemnation without health education may increase concealment rather than reduce risk. (World Health Organization, 2022; Creswell & Poth, 2018).

The study therefore recommends that health interventions avoid sensationalism. STI education should not portray LGBT persons as inherently diseased or dangerous. Such framing is scientifically inaccurate and may intensify discrimination. Prevention is more effective when it is evidence-based, confidential, non-judgemental, and culturally responsive. The integration of religiously sensitive communication with public-health expertise may provide a more constructive pathway in conservative communities. (Berger, 1967; Geertz, 1973).

Discussion: Religion, Agency, and Transformation

The overall pattern demonstrates that respondents are not passive recipients of social pressure. They actively interpret, reorganise, and adapt religious practices. This agency is central to the concept of transformative religious behaviour used in this study. Transformation does not necessarily mean abandoning tradition; it can involve changing the location, social form, intensity, or visibility of practice while maintaining core spiritual commitments. Such processes are consistent with Berger's (1967) argument that

individuals participate in the construction and maintenance of meaningful social worlds. (Becker, 1963; Goffman, 1963).

The findings also complicate the assumption that public religious visibility is a direct measure of religiosity. A person may be absent from a mosque because of anticipated stigma while remaining committed to prayer and fasting. Conversely, public participation does not automatically reveal the depth of private religious conviction. The five-dimensional approach of Glock and Stark (1965) is useful precisely because it allows these dimensions to be distinguished rather than collapsed into a single indicator. (Yip, 1997; Gross & Yip, 2010).

The interaction between Community Behaviour and Central Behaviour is evident throughout the data. Community expectations influence what is considered safe or appropriate, while personal experience determines how individuals respond to those expectations. Two people exposed to similar social norms may develop different strategies because their family histories, religious experiences, personalities, and support networks differ. Behaviour is therefore neither fully determined by society nor completely independent of it. (Goffman, 1959; Jenkins, 2008).

METHODS

This study employs a qualitative approach because the research question concerns meaning, experience, interaction, and adaptation. Quantitative indicators could identify frequencies of religious participation, but they would be less capable of explaining why a respondent prays privately, why another avoids a mosque, or how a person interprets a painful religious experience. Qualitative research is appropriate when researchers seek to understand participants' perspectives within their social contexts (Creswell & Poth, 2018). (Glock & Stark, 1965; Stark & Finke, 2000).

Data collection relies on in-depth interviews, participatory observation, and documentation. Interviews provide access to personal narratives, while observation helps situate those narratives within everyday interaction. Documentation contributes contextual information concerning religious institutions, community life, and relevant social conditions. Triangulation across these sources strengthens interpretive credibility by preventing the analysis from depending exclusively on a single type of evidence (Denzin, 1978; Lincoln & Guba, 1985). (Bandura, 1977; Berger & Luckmann, 1966).

The study requires heightened ethical sensitivity because respondents may face social consequences if identifiable information becomes public. Confidentiality, informed consent, careful pseudonymisation, and minimisation of unnecessary identifying details are therefore essential. Research involving stigmatised populations must ensure that academic visibility does not produce additional harm. Ethical reflexivity is not an administrative supplement; it is part of the validity of the research itself. (Tajfel & Turner, 1986; Jenkins, 2008).

RESULT

Theoretically, the study contributes to the sociology of religion by demonstrating that religious behaviour among marginalised sexual and gender minorities cannot be adequately

understood through institutional participation alone. It also contributes to stigma research by showing that stigma can shape the spatial and temporal organisation of religious practice. The findings further support an interactionist understanding in which identity is continuously negotiated through self-definition and social categorisation (Goffman, 1963; Jenkins, 2008). (Pargament, 1997; Mahoney, 2010).

Practically, religious institutions can contribute to reducing harmful stigma without abandoning their theological positions. This can be pursued through pastoral dialogue, protection from humiliation, confidential counselling, and emphasis on ethical treatment. The objective is not to prescribe a single theological interpretation but to encourage religious communities to distinguish doctrinal disagreement from interpersonal abuse, bullying, exclusion, or denial of basic human dignity. (Rodriguez & Ouellette, 2000; Kubicek et al., 2009).

For local government and health institutions, the findings suggest the need for culturally responsive STI prevention and health services. Programmes should involve health professionals, community leaders, educators, and where appropriate religious figures. Information should be scientifically accurate and framed in language that is understandable within the local moral context. Prevention should also include mechanisms that protect confidentiality so that fear of social exposure does not become a barrier to care. (World Health Organization, 2022; Creswell & Poth, 2018).

For families, the findings underline the importance of communication. Family rejection may increase isolation, whereas respectful communication can provide emotional and practical support even where family members retain moral or religious disagreement. The study does not assume that all families will reach identical conclusions. Rather, it emphasises that dialogue and non-violence are important conditions for managing disagreement without escalating social harm. (Berger, 1967; Geertz, 1973).

CONCLUSION

The study concludes that religious behaviour among LGBT community members in Central Lombok is contextual, adaptive, and transformative. Social-religious pressure does not automatically eliminate religious commitment. Instead, respondents develop strategies that allow them to preserve spirituality while managing stigma. These strategies include private worship, selective disclosure, participation in trusted small groups, alternative sources of religious learning, and careful negotiation of public identity. (Becker, 1963; Goffman, 1963).

The findings also demonstrate that the relationship between LGBT identity and religion is more complex than a simple opposition. Respondents may experience religion as a source of moral pressure and social exclusion while simultaneously experiencing it as a source of hope, meaning, discipline, and spiritual connection. This duality is central to understanding religious life in marginalised communities. It also confirms the usefulness of combining Community Behaviour, Central Behaviour, Glock and Stark's multidimensional approach, and stigma-labelling perspectives. (Yip, 1997; Gross & Yip, 2010).

The study recommends, first, strengthening dialogue between religious institutions, families, community organisations, and health professionals. Second, religious communities should develop mechanisms for preventing humiliation, bullying, and violence while maintaining space for theological discussion. Third, public-health agencies should provide confidential STI education, testing, and treatment based on evidence rather than stereotypes. Fourth, future research should compare Central Lombok with other Muslim-majority regions in Indonesia to determine which patterns are locally specific and which reflect broader dynamics. (Goffman, 1959; Jenkins, 2008).

Ultimately, the research argues for a more differentiated understanding of religious behaviour. The presence of stigma does not erase spirituality, and religious disagreement does not necessarily justify social exclusion or health neglect. A constructive response requires simultaneously recognising religious values, protecting human dignity, and addressing concrete public-health risks through evidence-based education. Such an approach can create a more analytically accurate and socially responsible understanding of LGBT religious life in Central Lombok. (Glock & Stark, 1965; Stark & Finke, 2000).

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