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Moderating Role of Religious Orientation in the Relationship of Perceived Mental Illness Stigma and Suicidal Ideation Among Filipino Young Adults

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Abstract. Due to underreported suicide cases and increasing mental health issues, the study examined the relationship between perceived mental illness stigma and suicidal ideation among young adults in a religious country like the Philippines, focusing on the moderating role of religious orientation. Through quantitative research employing a moderation model, 137 Filipino young adults working in private Catholic schools in Bulacan were purposively sampled. Three standardized questionnaires were adapted. Results revealed that perceived mental illness stigma was present at a below-average level. Suicidal ideation levels were generally very low over the year, but some participants had already experienced it from a young age. Filipino young adults exhibited high extrinsic and low intrinsic religious orientations. Using Pearson's correlation, findings indicated a positive significant relationship between perceived mental illness stigma and suicidal ideation, suggesting that higher levels of perceived stigma were linked to increased suicidal thoughts. As individuals perceive that they will be devalued and discriminated against for having a mental illness, there is also a higher tendency for them to be preoccupied with suicidal thoughts. However, the result of Hayes Process moderation analysis shows that neither extrinsic nor intrinsic religious orientation has an interaction effect with perceived mental illness stigma on suicidal ideation. The absence of interaction effect indicates that the correlation between the perceived stigma of having a mental illness and having suicidal thoughts remained consistent regardless of the religious orientation of Filipino young adults. Since it focused on a single religious group, the findings cannot be generalized due to sampling limitations.

Keywords: Extrinsic religious orientation; Filipino young adults; Intrinsic religious orientation; Perceived Mental illness stigma; Suicidal ideation.

1.0 Introduction

The World Health Organization (2021) considers suicide a serious public health concern, with more than 700,000 reported deaths every year. More than 70% of individuals with mental health problems did not seek help because of fear of prejudice and expected discrimination for being diagnosed (Henderson et al., 2013). In 2019, the suicide rate reported in the Philippines was 2.5 per 100,000 population (Department of Health, 2022). There is a significant level of stigma and discrimination toward mental health problems in the Philippines, wherein fear of being labeled as crazy and destroying family reputation keeps them from seeking professional help (Tanaka et al., 2018). Experiencing perceived or internalized stigma due to mental disorders and being burdened by harsh labeling and discrimination suggests a significant risk for suicide (Carpiniello & Pinna, 2017).

As proposed by Modified Labeling Theory (Link et al., 1989), stigmatization brings harmful consequences toward people with mental health conditions, wherein when people started to believe more that they would be devalued and discriminated against for having a mental illness, the more they began to feel threatened to interact with others. This approach proposed that mental illness stigma has a positive relationship with the suicidal ideation of people labeled as mentally ill by mental health services but not for unlabeled individuals (Oexle et al., 2017). In terms of perceived stigma, it is the one stigma mechanism shared by individuals with and without mental illness (Fox et al., 2018). Also, suicide cases are likely to be underreported in the Philippines because of cultural differences in the country, like religious beliefs, stigma towards the family, as well as lack of knowledge about suicide (Bangalan et al., 2023). There are also religious beliefs suggesting that having a mental illness results from having sinful behavior and its causes, as well as treatment, is spiritually oriented (Wesselmann & Graziano, 2010).

In a study with Filipino samples, it was found that there is very little difference between the rate of suicidal ideation of those who were currently religious-affiliated and those religious-none affiliated, but those who have religion but lost it have a higher chance to succumb to suicidal ideation (Quintos, 2018). Still, there are inconsistent findings on how religious orientation takes part in mental health issues, specifically stigma and suicidal ideation. As defined, suicidal ideation occurs when someone has contemplations and preoccupation with wishes or ideas of death and suicide (Harmer et al., 2022). The combination of perceived burdensome and perceived social isolation is where suicidality stems from, and their simultaneous presence is the cause of the perilous suicidal desire (Van Orden et al., 2010). There were controversies about the role of religiosity in suicidal ideation because of contradicting results in different studies (Dueñas et al., 2019). It was reported in the study of Lester (2012) that the association between religiosity and suicidal ideation is not always found, such as in his research wherein suicidal behavior is not significantly associated with any variables in the study, including intrinsic and extrinsic religiosity. Religious orientation was used as a moderator in a study about religiosity and prejudice (Vazquez & McClure, 2017). However, based on the reviewed studies, its moderating role in the relationship between perceived mental illness stigma and suicidal ideation is still unknown. Moreover, the protective effect of religiousness is found to be most salient among older adults (Levin, 2010), but little is known among young adults.

Furthermore, the study of Levin (2010) suggests that individuals' religious lives, including their religious identity, might have something significant to say in describing their mental health. Since the Philippines is a predominantly Roman Catholic Country, it is also possible that the social norms and beliefs associated with their religion contribute to suicide prevention (Redaniel et al., 2011). Previous studies suggest that religious involvement serves as a factor that protects people against psychological distress and mental illness (Levin, 2010), and spiritual coping shields individuals from experiencing stigma (Tanaka et al., 2018). However, a study with Filipino samples suggested that their sense of religiosity or spirituality is one of the sociocultural barriers to their formal help-seeking (Martinez et al., 2020).

As religion and religiosity are separate concepts, being religious does not necessarily mean having a religious affiliation (Pace, 2014). Religious orientation is one way of conceptualizing and operationalizing a person's religiosity (Vazquez & McClure, 2017). Allport and Ross (1967), in their Intrinsic-Extrinsic Framework of Religious Orientation, highlighted that the best way to differentiate the poles of subjective religion is when people "use" their religion, they are extrinsically motivated, while those who 'live' their religion are intrinsically motivated. It is assumed in this framework that intrinsic religious orientation (IRO) is embodied with more positive consequences of religion, such as lower suicidality. In contrast, extrinsic religious orientation (ERO) is related to having more negative outcomes (Lew et al., 2018). Extrinsic religious orientation (ERO) is described as instrumental, wherein individuals use their religiousness to meet their social and psychological ends, while intrinsically religious-oriented (IRO), individuals tend to seek reward within their beliefs in the supernatural realm (Lavrič & Flere, 2011). It is essential to understand if there are any religious-based stereotypes regarding mental illness for them to be targeted in anti-stigma campaigns (Wesselmann & Graziano, 2010).

In particular, the goal of the study was to examine if there is an interaction effect between perceived mental illness stigma and being intrinsically or extrinsically religious oriented on suicidal ideation among Filipino young adults. Using religious orientation as a moderator is based on the notion that it has opposing associations with the individual's well-being, either harmful or helpful (Doane et al., 2013). Figures 1 and 2 show the hypothesized correlation models of perceived mental illness stigma (X) and suicidal ideation (Y) as moderated by extrinsic and intrinsic religious orientation (W), respectively. The current study aimed to examine if there is an interaction effect

between perceived mental illness stigma and being extrinsically religious oriented (see Figure 1) or intrinsically religious oriented (see Figure 2) on suicidal ideation among Filipino young adults. In particular, the study aimed to examine the following research questions: (1) What is the level of perceived mental illness stigma, suicidal ideation, and religious orientation (extrinsic/intrinsic) of Filipino young adults? (2) Is there a significant correlation among perceived mental illness stigma, suicidal ideation, and religious orientation (extrinsic/intrinsic) of Filipino young adults? (3) Does religious orientation (extrinsic/intrinsic) moderate the relationship between perceived mental illness stigma and the suicidal ideation of Filipino young adults?

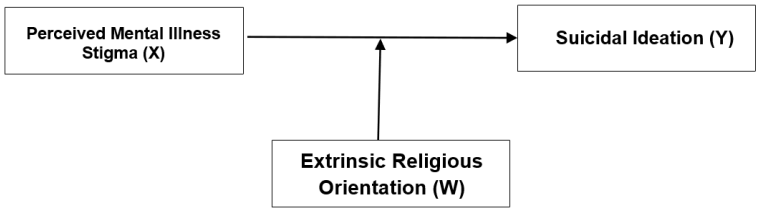

Figure 1. *The hypothesized moderation model of perceived mental illness stigma, suicidal ideation and extrinsic religious orientation*

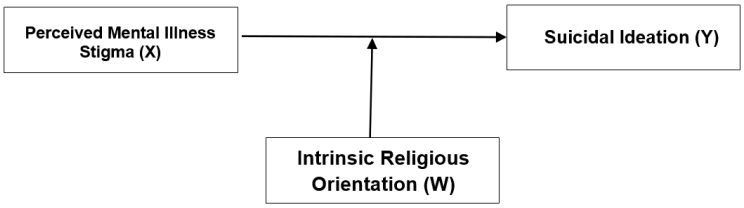

Figure 2. *The hypothesized moderation model of perceived mental illness stigma, suicidal ideation, and intrinsic religious orientation*

As anchored to the Modified Labeling Approach, the objective of the study was to examine whether the association of perceived mental illness stigma and suicidal ideation found in previous research also applies to how unlabeled individuals perceived mental illness in a predominantly religious country like the Philippines. Unlike in previous studies, the moderating role of religious orientation was also analyzed. It is to test whether having a low perceived mental illness stigma also lowers the tendency of a person to experience suicidal ideation, and if it is true, more for those with high intrinsic than extrinsic religious orientation. In the current study, the association of perceived mental illness stigma and suicidal ideation was tested not only with individuals diagnosed with mental health problems but also with nonclinical samples to test how the public perceives mental illness and how it affects the risk of having suicidal thoughts of those living in a religious community. Due to prevalent mental health issues and underreported suicide reports, the study is beneficial in improving mental health literacy in a religious country like the Philippines. Results will bring awareness to suicide prevention by breaking the stigma that having a mental illness is caused purely by a lack of faith and poor religious involvement of a person.

2.0 Methodology

2.1 Research Design

The study utilized explanatory, non-experimental quantitative research using a moderation model. Moderation analysis is used when the goal of a study is to test when or under what condition the independent variable (IV) exercises an effect on the dependent variable (DV), as well as to test whether a third variable or moderator influences the magnitude of the causal effect of IV on DV (Hayes & Little, 2022). The study examined whether the relationship between perceived mental illness stigma and suicidal ideation was moderated by being extrinsically or intrinsically religious-oriented, of a person. The time dimension is cross-sectional because it was conducted over a single period.

2.2. Research Participants

Participants were purposively sampled from selected religious Catholic schools in Bulacan. The sample comprised 137 Filipino young adults aged 18-35 working as personnel (teaching/non-teaching staff) in private Catholic schools. In purposive sampling, particular persons or settings were selected purposefully to give substantial information that cannot be obtained from other choices and warrants inclusion (Taherdoost, 2016). In this study, participants exposed to religious environments and practices were purposively sampled. Based on Green's formula, the general rule of thumb is to have no less than 50 participants for regression or correlation, wherein N>50+8m for analyzing multiple correlations and N>104+m for analyzing individual predictors (Memon et al., 2020). The m in the formula is the number of independent variables used. In this study, there is one independent variable and one moderator. The researcher followed Green's general rule of thumb for regression of N>104+m, wherein m equals 2. Replacing the values, N>104+2, the N>106. Thus, the minimum sample size in the study should be 107 or more.

2.3 Research Instrument

Three standardized instruments were adapted to measure perceived mental illness stigma, suicidal ideation, and religious orientation (extrinsic/intrinsic). These instruments were also reviewed and utilized in other published studies. The Perceived Devaluation-Discrimination (PDD) Scale (Link et al.,1989) measures how most individuals negatively view people with mental illness and is oriented toward evaluating what others think and grasp their social perception of devaluation and discrimination regarding mental illness (Oexle et al., 2017; Mora-Ríos & Ortega-Ortega, 2021). It can be answered by patients and nonpatients, wherein labeled individuals may feel that these beliefs about other people's opinions may apply to them. At the same time, for those unlabeled, they may be an innocuous array of beliefs of what others perceive those with mental health conditions. It was measured via a 6-point level of agreement scale with "strongly agree = 1" to "strongly disagree = 6" to measure the level to which participants perceive how most individuals will discriminate or devalue a person with a mental illness. It has 12 items, wherein 6 of them are reversely scored. In the PDD Scale, higher mean values indicate higher perceived mental illness stigma. A reliability of α=0.79 was reported for the 12-item PPD scale.

The Suicidal Ideation Scale (SIS) (Rudd, 1989) evaluates the intensity or severity of a person's suicidal ideation via self-report. SIS is a 10-item self-report screening tool that assesses the absence or presence of suicidal ideation, the intensity of suicidal thoughts, and even the absence or presence of former suicide attempts. It was designed to measure suicidal ideation that can be used for both non-clinical and clinical populations (Rudd, 1989; Luxton et al., 2011). Items on SIS are rated using a 5-point Likert scale ranging from "never=1" to "always=5" to assess how the respondents behaved or felt over the past year. In SIS, higher total scores indicate higher suicidal ideation. A reliability of α=0.95 was reported for the 10-item SIS scale.

Being intrinsically and extrinsically religious oriented was measured using the 21-item Intrinsic-Extrinsic Religious Orientation Scale (IEROS). The initial 20-item self-report Religious Orientation Scale (ROS) developed by Allport and Ross in 1967 was modified by members of the Harvard University seminar as a 21-item scale by adding one extrinsic item (item 21) from Feagin's revision in 1964 (Brewczynski & MacDonald, 2006; Khodadady & Golparvar, 2012). Items are scored wherein a response of "agree" (4) or "strongly agree" (5) on the extrinsic subscale items (12 items) indicates a greater extrinsic religious orientation, whereas a score of a response of "agree" or "strongly agree" on intrinsic subscale (9 items) indicate greater intrinsic religious orientation; a higher total score for each of the subscale corresponds to greater level of the respective religious orientation. The reliability for extrinsic and intrinsic subscales was α=0.79 and α=0.82, respectively (Ghazaei et al., 2020).

2.4 Data Gathering Procedure

The proposed study was presented to a panel of Psychology experts to review its objectives and procedure. After obtaining clearance from the Ethics Review Board, the researcher sought permission from the administration of the selected private Catholic schools to conduct the survey. The researcher utilized printed and online survey forms. Due to the busy schedules of the personnel, some requested that the survey be conducted online for easy access. In line with this, the researcher sought assistance in forwarding the Google form survey to their personnel. To ensure the integrity of the data, participants can only access and respond to the Google form once. Aligned with the APA code of ethics, the researcher obtained informed consent from the participants using language they could easily understand. Informed consent was attached to the survey form explaining the nature and purpose of

the study and their rights as participants, including their right to withdraw. The researcher took adequate measures to ensure the confidentiality and anonymity of the gathered data in surveys. The names of the institutions were kept anonymous as per their requests. Participants were asked to complete three standardized questionnaires, which may take 10-15 minutes only. Since suicidal ideation is a sensitive mental health issue, the researcher explained that it is entirely voluntary, and they are free to withdraw anytime. The data collection was from November 17, 2023, until February 16, 2024.

2.5 Ethical Considerations

Ethical considerations were observed to ensure that no study participants were harmed. Informed consent was given to explain their rights as participants. Participation is voluntary; money or any form of compensation was not given. Since the research has a sensitive topic that may pose minimal risk, respondents are also free to withdraw at any time without any consequence. In cases wherein participants may feel uncomfortable with some questions and want to withdraw from the research, they are free to do so and may contact the researcher for proper debriefing if needed. Results were treated anonymously to protect the identity of the participants and the institution. All survey results were treated with the utmost confidentiality and were viewed only by the researcher. The researcher secured the personal information following the RA 10173-Data Privacy Act of 2012 to maintain confidentiality. If there were any concerns, such as the need for debriefing, the participants may contact the researcher via email.

2.6 Data Analysis

The Statistical Package for Social Sciences (SPSS) was utilized for data analysis. The demographic profile of the participants and level of study variables were analyzed using descriptive statistics. It includes measures of central tendency, frequency distribution, percentage analysis, and standard deviation. Tests of assumptions were also initially addressed. The normality of data was tested using the Shapiro-Wilk Test, while multicollinearity was analyzed by calculating the variance inflation factor (VIF). Autocorrelation was tested using the Durbin-Watson test, while the Breusch-Pagan test was used to determine the presence of heteroscedasticity. Pearson's r correlation was used to measure the degree of correlation of the study variables: perceived mental illness stigma, religious orientation (extrinsic/intrinsic), and suicidal ideation. Hayes Process Macro Moderation Analysis was utilized to test the moderating effect of religious orientation (extrinsic/intrinsic) in the relationship between perceived mental illness stigma and suicide ideation. A simple moderation model in the Hayes Process with a variable moderating the effect of the independent variable on the dependent variable can be estimated using model=1 (Hayes & Little, 2022). The moderation analysis examines how the moderating variable changes or influences the strength or direction of the relationship between the predictor and outcome variables (Cunningham & Lucksted, 2017). Moderation assumptions were initially addressed before performing the moderation analysis.

3.0 Results and Discussion

3.1 Profile of the Participants

Based on the analyzed profile of the participants, their average age was 27 years old. All participants were Catholic. The majority of them were female (73%) than male (27%). Most were teachers (74.5%) and some were non-teaching personnel (25.5%). In tracing the history of mental illness, 6.6% of the respondents had been clinically diagnosed with mental illness, and the rest were not. In terms of knowing people with mental illness, about 48.2% of the participants knew someone (e.g., family, relatives, friends, colleagues, acquaintances) who was diagnosed with mental illness. Also, about 35 % of the participants felt the need to consult a mental health professional for help but were afraid to do so because of fear of stigma attached to it. In terms of having a history of suicidal ideation, 35% of the respondents have already experienced having suicidal thoughts or been preoccupied with ideas of ending their life. It was at the age of 17-26 years old wherein 24.8% of the respondents started to experience suicidal ideation, while 6.6% at age 13-16, and 3.6% at age 27-35 years old.

3.2 Perceived Mental Illness Stigma, Suicidal Ideation, and Religious Orientation

Table 1 shows the level of perceived mental illness stigma, suicidal ideation, and religious orientation (extrinsic/intrinsic) of Filipino young adults. The results show that participants have a below-average level of perceived mental illness stigma (M=3.47; SD=0.76), indicating a milder degree of negative perception, discrimination, and devaluation against having a mental illness. Filipino young adults working in Catholic schools, regardless of whether they were clinically diagnosed with mental illness or not, have a minimal level of

negative perception towards people with mental illness. Based on the reported profile, only 35% of Filipino young adults reported that they had felt the need to seek consultation from a mental health professional but were afraid to seek help because of fear of stigma attached to having mental illness. It can be implied that, in general, Filipinos in this age group were more accepting and understanding of mental health issues, viewing them as less stigmatizing.

Table 1. *Descriptive statistics of perceived mental illness stigma, suicidal ideation and religious orientation*

Variables	Mean	Standard Deviation	Interpretation
1. Perceived Mental Illness Stigma	3.47	0.76	Below Average
2. Suicidal Ideation	1.52	0.74	Very Low
3. Intrinsic Religious Orientation (IRO)	2.35	0.58	Low
4. Extrinsic Religious Orientation (ERO)	3.47	0.50	High

Participants also experienced very low levels of suicidal ideation over the past year (M=1.52; SD=0.74) since the study was conducted. Even if the overall mean score suggests a low frequency of suicidal ideation, the results show that some participants experience underlying pain and hopelessness in some of the items, which call for support and intervention. Some of the participants reported that they had already experienced suicidal thoughts as early as the age of 13-16 (6.6%), some around age 17-26 (24.8%), and others at age 27-35 (3.6%). Findings imply that even if suicidal ideation may not be prevalent overall, its seriousness and effects should not be undervalued.

Based on the result, Filipino young adults have high levels of being extrinsically religious oriented (M=3.47; SD=0.507) and low levels of (M=2.35; SD=0.584) being intrinsically religious oriented. Consistently, individuals have various motivations for their religious involvement, such as seeking solace in times of personal troubles, having spiritual growth, and building supportive social relationships (Doane et al., 2013). Extrinsically religious oriented individuals see their religion as acquiring certain self-serving ends. This is less significant for those intrinsically oriented because they make their needs and wants compatible with their religious beliefs (Moradi & Langroudi, 2013). The result implies that participants working in religious institutions were highly extrinsically religiously oriented, which is usually manifested in their active participation in various religious activities. In contrast, they were less inclined to be intrinsically religiously oriented, which can be observed in their level of conviction, internalization, and personal dedication to their religious creed. Results suggest that the divergent patterns discovered between extrinsic and intrinsic religious orientation underscore how individuals participate and extract significance from religion.

3.3 Relationship between Mental Illness Stigma, Suicidal Ideation and Religious Orientation

Table 2 shows the correlation matrix of the study variables. Perceived mental illness stigma has a significant positive relationship with suicidal ideation (r=.257, p=.002) which suggests that as the level of perceived mental illness stigma increases, the level of suicidal ideation of an individual increases at the same time. As young adults perceive that they will be devalued and discriminated against for having a mental illness, there is also a higher tendency for them to be preoccupied with suicidal thoughts. The greater the perceived mental illness stigma in the environment where an individual lives, the more likely they are to experience intense thoughts of ending their own lives.

Table 2. *Correlation matrix of perceived mental illness stigma, suicidal ideation and religious orientation*

	1	2	3	4
1. Perceived Mental Illness Stigma	—			
2. Suicidal Ideation	0.25**	—		
3. Intrinsic Religious Orientation (IRO)	0.04	0.07	—	
4. Extrinsic Religious Orientation (ERO)	-0.11	-0.09	-0.40***	—

*p<.05, ** p<.01, *** p<.001

The findings were consistent with previous studies indicating that stigma associated with mental illness contributes significantly to suicidal ideation (Carpiniello & Pinna, 2017; Oexle et al., 2016; Hirsch et al., 2019). Besides people who were labeled as mentally ill, those individuals who are experiencing problems in emotional clarity have increased vulnerability to suicidal ideation because of perceived stigma (Oexle et al., 2016). In addition, it is supported by what Schomerus et al. (2015) hypothesized that having higher levels of social acceptance among persons with mental illness leads to lower suicide rates, and the presence of stigma is associated with higher suicide prevalence. The null hypothesis suggesting the absence of a significant correlation between

perceived mental illness stigma and suicidal ideation was rejected. In terms of religious orientation, intrinsic religious orientation was negatively correlated with extrinsic orientation (r= -0.406, p<.001), suggesting that as people see their religious involvement more as embracing their religion's creed, they see their religion as less instrumental, not using it to satisfy their needs.

Meanwhile, the result shows that perceived mental illness was not significantly correlated with both extrinsic (r=-0.114, p=.186) and intrinsic (r=.042, p=.629) religious orientation. No significant correlation was also found between religious orientation, whether it is extrinsic (r=-.096, p=.266) or intrinsic (r=0.077, p=.374), and suicidal ideation. Inconsistent with the belief that a conception of a religious individual on faith and prayer may also affect how they view mental illness (Wesselmann & Graziano, 2010), there is not enough evidence to conclude that individuals experiencing suicidal ideation do not pray nor attend church (extrinsic) or have no faith in the supernatural realm (intrinsic). The result suggests that a person cannot easily associate someone's suicidal ideation with having poor religious involvement.

The present findings answer a few of the most infamous quotes and beliefs of many Filipinos that a person who experiences mental health problems is "Kulang sa dasal" and "Hindi kasi nagsi-simba" (Brillantes & Rodenas, 2022). It is consistent with the study of Wang et al. (2014), which found that religious involvement and suicidal ideation, planning, or attempt were not significantly correlated even with a religious group known for having the lowest rate of suicide in the world. It only suggests that even a religious person may experience having suicidal thoughts. However, it is not related to having poor faith because there are still other factors that may contribute to it. Furthermore, Hills and Francis (2005) found that no significant difference was found between the suicidal ideation scores of those churchgoers who attended church at least weekly and those who attended less frequently. It is supported by Lawrence et al. (2015) that being part of a religious group and regularly attending religious services could serve as protective factors against attempting suicide, although not necessarily against having suicidal thoughts.

Moreover, it suggests that religious involvement may act as a preventive factor in suicidal attempts, but it is not the same as having suicidal thoughts. It implies that a person may have suicidal thoughts but would never put them into action because of their religion. The findings suggest the importance of continuous and long-term comprehensive programs that focus more on reducing the negative impact of perceived mental illness stigma towards risk of suicidal ideation.

3.4 Role of Religious Orientation in the Relationship between Perceived Mental Illness Stigma and Suicidal Ideation

In analyzing the results, moderation assumptions were initially addressed before the moderation analysis. The data has acceptable normality (Skewness= 0.00769 to 1.81 < 2.00, acceptable), based on the general guideline of Hair et al. (2022) and George and Mallery (2010) that a skewness value between -2 and +2 is acceptable and can be considered adequate to prove normal data. The calculated variance inflation factor (VIF) in the study suggests the absence of multicollinearity (VIF=1.013 to 1.211< 5.00); multicollinearity only exists if VIF is greater than five (Kim, 2019). The Breusch-Pagan test was used to determine the presence of heteroscedasticity, wherein a null hypothesis assumes that homoscedasticity is present, and rejecting it suggests the presence of heteroscedasticity (Bobbitt, 2022). The data shows the presence of homoscedasticity (BP test=0.87277, p=0.6464). Autocorrelation was tested using the Durbin-Watson test; values range from 0 to 4, wherein a value close to 2 or in the middle of the range suggests less autocorrelation, while values closer to 0 or 4 suggest greater positive or negative autocorrelation, respectively (Statistics Solutions, 2021). The result shows non-autocorrelation (DW Statistic=1.94; p=0.3221). After checking these assumptions, the Hayes Process moderation analysis was performed with means centered on constructing products for continuous variables in the model. Two moderation models were run in the study.

Tables 3 and 4 show the Hayes Process Macro Moderation analysis results in examining the moderating role of extrinsic and intrinsic religious orientation. Based on the result presented in Table 3, perceived mental illness stigma (B=2.477 p=.003) significantly predicts suicidal ideation, unlike extrinsic religious orientation (B=-.089 p=.378), and their interaction term (B=-0.208, p=.131) is statistically not significant. Overall, the variables contributed an 8.7% variance in suicidal ideation ($F(3,133)=4.198$, p=.007). Still, the interaction of perceived mental

illness stigma and extrinsic religious orientation only had a 1.6% additional variance to suicidal ideation (ΔR^2=.016, p=.131). Adding extrinsic religious orientation in the regression model did not moderate the relationship between perceived mental illness stigma and suicidal ideation. Thus, there is no interaction effect between perceived mental illness stigma and extrinsic religious orientation on suicidal ideation of Filipino young adults. The findings suggest that the correlation between the perception of stigma towards having mental illness and the tendency to have suicidal thoughts is relatively consistent regardless of the instrumental motivation of individuals toward their religious involvement or their extrinsic orientation as defined. It is aligned with previous studies that found that the history of suicidal ideation was not significantly related to extrinsic religiosity (Lester, 2017; Walker et al., 2014). Furthermore, the study of Lester and Walker (2016) found that being extrinsically religious-oriented, such as the associated benefits of attending church, does not significantly predict suicidal ideation.

Table 3. *Moderation analysis of extrinsic religious orientation in the relationship between perceived mental illness stigma and suicidal ideation*

Variables	Suicidal Ideation (Y)					
	B	SE B	T	p-value	Decision	Remarks
(Constant)	15.2*	0.61	25.0	0.00	Reject Ho	Significant
Perceived Mental Illness Stigma (X)	2.47*	0.81	3.05	0.00	Reject Ho	Significant
Extrinsic Religious Orientation (W)	-0.08	0.10	-0.88	0.37	Accept H0	Not Significant
X x W	0.20	0.13	1.51	0.13	Accept H0	Not Significant

Note. R^2=.087, $F(3, 133)$= 4.198 , p=.007; ΔR^2 =.016, $F(1,133)$=2.309, p=.131, *p<.05

Meanwhile, Table 4 presents the result of regression analysis in examining the moderating role of intrinsic religious orientation in the relationship between perceived mental illness stigma and suicidal ideation. Altogether, 9.1% of the variability in suicidal ideation was predicted by the study variables (R^2=.0908, $F(3, 133)$=4.4272, p=.0053). Consistently, perceived mental illness stigma (B=2.3015, p=.0053) was a positive significant predictor of suicidal ideation, while intrinsic religious orientation (B=.1060, p=.3616) was not. The interaction effect between perceived mental illness stigma and intrinsic religious orientation was statistically not significant (B=-0.2608, p=.0874), and this interaction only had 2% additional variance towards suicidal ideation (ΔR^2=.0203, $F(1,133)$=2.9661, p=.0874).

Table 4. *Moderation analysis of intrinsic religious orientation in the relationship between perceived mental illness stigma and suicidal ideation*

Variables	Suicidal Ideation (Y)					
	B	SE B	t	p-value	Decision	Remarks
(Constant)	15.2*	0.60	25.1	0.00	Reject Ho	Significant
Perceived Mental Illness Stigma (X)	2.30*	0.81	2.83	0.00	Reject Ho	Significant
Intrinsic Religious Orientation (W)	0.10	0.11	0.91	0.36	Accept H0	Not Significant
X x W	-0.26	0.15	-1.72	0.08	Accept H0	Not Significant

Note. R^2=.091, $F(3, 133)$=4.427 , p=.005 ; ΔR^2=.020, $F(1,133)$=2.966, p=.087, *p<.05

Findings suggest that although intrinsic religious orientation (IRO) or being involved in religion to embrace their religious creed may have some effect on mental health outcomes, its influence on having suicidal thoughts seems to be fairly insignificant when compared to the impact of perceived mental illness stigma. The finding aligns with the study of Lawrence et al. (2015) that intrinsic religious orientation, like praying and being affiliated with a particular religion, is not a sufficient protective factor for suicidal ideation. It suggests that religiosity may act as a preventive factor in suicidal attempts but not in suicidal ideation. It can also be further explained by the study of Hajiyousouf and Bulut (2022) that regardless of their faith, even individuals from religious communities that condemn the act of suicide may also experience suicidal ideation or have thoughts to end their life to end problems or suffering, as the likely the same way from those in non-religious societies.

In the two moderation models, it was consistently shown that the substantial influence of perceived mental illness stigma on suicidal ideation among Filipino young adults, wherein the influence of either extrinsic or intrinsic religious orientation seems to be insignificant in this situation. Results align with prior studies suggesting a positive relationship between the perception of stigma surrounding mental illness and the occurrence of suicidal thoughts (Arria et al., 2011; Lew et al.,2018). Findings also emphasized that the chances of having suicidal ideation may still occur, and even a very religious person may still experience having suicidal thoughts because of different life factors. Again, these results were consistent with the claims of Ooi et al. (2021) that there is inconsistency in the findings in research concerning religious orientation. Lawrence et al. (2015) further suggest that while religious individuals may have various strategies to manage their suicidal ideation, it does not necessarily mean they will

have fewer suicidal thoughts, nor does it always lead to completely preventing them. Findings imply that caution should be made in generalizing the predictive power of religious orientation in mental health concerns and various factors like stigma could have more influence on the risk of having suicidal thoughts.

4.0 Conclusion

The findings highlight that among the study variables, only perceived mental illness stigma has a positive, significant relationship with suicidal ideation of Filipino young adults. As individuals perceive that they will be more devalued and discriminated once they are labeled as mentally ill, they also have a higher tendency to experience suicidal ideation. Meanwhile, the absence of a significant interaction effect of religious orientation implies that the connection between how mental illness stigma is perceived and having suicidal thoughts remains consistent regardless of an individual's motivation for their religious involvement. Regardless of the motivation of Filipino young adults towards their religious involvement, it is for embracing religious creed (intrinsic) or for personal gain (extrinsic), it is not related to how they negatively perceive people with mental illness and their risk of having suicidal thoughts. Adding extrinsic or intrinsic religious orientation in the moderation model only contributed to a minimal variance in suicidal ideation compared with the impact of perceived mental illness stigma. Thus, the correlation between the perception of stigma surrounding mental illness and the presence of suicidal thoughts remains consistent regardless of an individual's religious orientation.

Generally, the study provides insights about the complex nature of suicidal ideation and the harmful impact of perceived mental illness stigma in a religious country like the Philippines, while also explaining the various ways in which religious orientation may or may not influence it. Furthermore, even if suicidal ideation and stigma against mental illness may not be prevalent overall among the age group of Filipino young adults, its seriousness and effects should not be undervalued. It is essential to recognize the potential severity and significance of even brief suicidal thoughts. In line with this, the study encourages mental health professionals to constantly remind the public to be cautious in making broad generalizations about the predictive power of religious orientation and enlighten them that although it may have some effect on mental health outcomes, a multitude of factors like stigma can have more impact in terms of having suicidal ideation. It includes acknowledging that the influence of religious involvement may not be uniform across different populations. Despite existing mental health programs, the findings recommend the need for accessible and long-term anti-stigma programs to combat mental health stigma in the Philippines.

The findings, however, should be interpreted with caution due to the sampling limitation. Additionally, focusing on single religious groups means that the conclusions may only apply to some religious settings and cannot be generalized. It is recommended for future researchers to include a varying level of religiosity in different religious denominations in studying the aspects of religious orientation, perceived mental illness stigma, and suicidal ideation.

5.0 Contributions of Authors

The research was conceptualized, analyzed, and finalized by the corresponding author, Hanna Mae A. Caparas, under the supervision and insightful feedback of her thesis adviser, Dr. Ian I. Llenares.

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7.0 Conflict of Interest

The authors have no conflict of interest in this research.

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