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Religiosity evidence of residents in city south of Minas Gerais

Evidências de religiosidade em residentes de cidade sul mineira*

Evidencia de religiosidad en los residentes de la ciudad sul mineras

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ABSTRACT

Objective: To evaluate the religiousness and to relate the biosocial characteristics to the religiousness. **Methods:** A quantitative and descriptive research done with 600 people living in Itajubá, MG. Two instruments were used. **Results:** It was found that 29% would go to the church once a week; 42,5% dedicate their time to individual religious activity, daily; 74% feel the presence of God in life; 57% mentioned that their religious beliefs guided their way of living; 50,5% would make great efforts to like their religion. Women were more religious than men (RO p<0,004; RNO e RI p<0,001); people with lower schooling, except RO (p=0,083), were more religious (RNO p=0,001 e RI p<0,02). People with religious practice had more religiousness than those not practicing any religion (p<0,001). **Conclusion:** Religiousness evidences were identified among the three types of religiousness.

Descriptors: Religion, Spirituality, City, Nursing.

[1] Article extracted from entitled work: Brazilian culture validation from Duke- University Religious Index (DUREL). Year of 2009.

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RESUMO

Objetivos: Avaliar a religiosidade e relacionar com ela as características biossociais. **Métodos:** Trata-se de um estudo de abordagem quantitativa, do tipo descritivo, realizado com 600 pessoas residentes em Itajubá, MG. Foram utilizados dois instrumentos. **Resultados:** Encontrou-se que 29% dos entrevistados iam uma vez por semana à igreja; 42,5% dedicavam, diariamente, o seu tempo a atividades religiosas individuais; 74% sentiam a presença de Deus em sua vida; 57% mencionaram que as crenças religiosas estavam inseridas em sua maneira de viver; 50,5% se esforçavam muito para viver a sua religião. As mulheres eram mais religiosas do que os homens (RO p<0,004; RNO e RI p<0,001); as pessoas com menos escolaridade, com exceção da RO (p=0,083) eram mais religiosas (RNO p=0,001 e RI p<0,02). As pessoas com prática religiosa tinham maior religiosidade do que aquelas que não praticavam uma determinada religião (p<0,001). **Conclusão:** Identificaram-se evidências religiosas entre os três tipos de religiosidade.

Descritores: Religião, Espiritualidade, Cidade, Enfermagem.

RESUMEN

Objetivos: Evaluar la religiosidad y se refieren a ella las características biosociales. Métodos: Este estudio es cuantitativo, descriptivo, realizado con 600 residentes en Itajubá, MG. Se utilizaron dos instrumentos. **Resultados:** Se encontró que el 29% de los encuestados fue una vez a la semana a la iglesia; 42,5% dedicada a diario, su tiempo a actividades religiosas individuales; 74% sintió la presencia de Dios en su vida; 57% mencionó que las creencias religiosas fueron colocados en su forma de vida; 50,5% están muy tratando de vivir su religión. Las mujeres eran más religiosas que los hombres (RO p <0,004; RNO e IR p <0,001); las personas con menos educación, a excepción de RO (p = 0,083) fueron más religiosa (RNO p = 0,001 e IR p <0,02). Las personas con las prácticas religiosas eran más religiosos que los que no practican una religión en particular (p <0,001). **Conclusión:** Identificaron pruebas religiosa entre los tres tipos de religiosidad.

Descriptores: Religión, Espiritualidad, Ciudad, Enfermería.

INTRODUCTION

The relationship between religion, religiosity and health have been increasingly researched and emerge as relevant areas in the current research, both in the humanities,[1] as in the natural sciences.[2] There is currently a large, diversified and consistent body of evidence showing the relevance of religion to a better understanding and health care of individuals and populations. Studies indicate that much of the world's population is religious.[3] Religion is often used by people in coping with stressful situations and religious involvement is usually related to better health indicators, such as lower rates of depression, suicide, drug use, mortality and better quality of life.[4,-5]

Religiosity and spirituality are integral dimensions of social and cultural human experience and thus the daily life of most of the population. A study of the World Health Organization (WHO) investigated 5,087 people in 18 countries, and among the Christian countries outside Africa, Brazil had the highest percentage of respondents who indicated “moderately” or “extremely” religious (80% to 90%).[6]

Data from the census conducted in 2000 show that a share more than 90% of the population has some religious denomination and large part of the population has some form of spiritual expression or religious involvement.[7] These data coincide with a national population survey involving 3,007 participants, a representative sample of the population.[3] According to this study, only 5% of Brazilians reported having no religion, 83% considered the religion very important in their life and 37% attended a religious service at least once a week. The most common religious affiliations were Catholicism (68%), Protestant / Evangelical (23%) and Kardecist Spiritualism (2.5%).[3]

Religion is an organized system of beliefs, practices, rituals and symbols designed to facilitate closeness to the sacred and the transcendent (God, higher power or absolute truth).[4] Religiosity refers to the degree of participation and adherence to the beliefs and practices of a religious system.[2] It refers to the level of religious involvement and the reflection of that involvement in one's life, how it affects their daily lives, their habits and their relationship with the world.[1] Religiosity is an organized system of beliefs, practices, rituals of worship, doctrine and symbols designed to facilitate closeness to the sacred and the transcendent shared specifically with a group.[8] It is a way for the relationship with a Higher Being, something or someone greater than the physical world.[9]

The religion of an individual may be intrinsic or extrinsic orientation. In religiosity of intrinsic type, people have religion as their highest good and other needs seen as minor. In general, other issues are placed in harmony with its orientation and religious belief. In the extrinsic religiosity, religion is a way used by the individual for other purposes or interests, sociability and distraction, status and self-absolution.[4,6]

Spirituality means the possibility of a person diving in itself. It's all an experience that can produce profound change within man and leads to personal integration and other human beings. It is related to values and meanings: the spirit allows you to experience the depth, the symbolic capture, show that life is driven by a sense and only the spirit is able to discover a meaning to existence.[10] Another important variable in defining what would be spirituality: “Spirituality is the construction or meaning of discovery in the middle of relationships or interactions between the person, the other and the world.”[11]

Although the definitions are different between religiosity and spirituality, these terms are often used interchangeably in empirical studies.[12] However, there is still intense epistemological debate on the use of these concepts. To standardize the information in this study it was used the concept of Sullivan[13] to spirituality, which refers to an individual and unique feature that may or may not include belief in a “God”, and those responsible for the connection of the “I” with the universe and with

others, which is also beyond religiosity and religion[14]; for religiosity, which is the belief and practice of the fundamentals proposed by a religion.

Beliefs and religious services often can help patients manage to face adversity better from a disease process. When people turn to religion to cope with stress, it is characterized called religious-spiritual "coping",[15] which is defined as "the use of religious beliefs and behavior to facilitate troubleshooting and prevent or alleviate the emotional consequences negative stressful life circumstances. " Almost all studies in healthy populations suggests that religious beliefs and practices are associated with greater psychological well-being, greater "coping" and better mental health.[5]

In Brazil, the Federal Constitution (FC), in Article 5, the Federal Law No. 9,982 / 2000 and state laws ensure and regulate the religious assistance in hospitals, if carried out in agreement with patients and their families in the case of patients are not in possession of his mental faculties. The Constitution provides that "is guaranteed under the law, the rendering of religious assistance in civil and collective military hospital" (CF, art. 5, VII). In 2000, the Federal Law No. 9,982 / 2000 (the "Pastoral Care in the Hospital Entities Public and Private, and Prisons Civil and Military") came to regulate this practice, providing for the provision of religious assistance in public and private hospital entities, as well as in civil and military prisons. In Article 1, the law states that "to religious of all faiths ensures access to hospitals in the public or private network as well as to civilian prisons or military, to give religious assistance to hospitalized since in agreement with these, or with your family in the case of patients who are no longer in possession of his mental faculties. " The realization of religious assistance, therefore, does not go through the therapy team's decision Hospital where the patient is hospitalized. [16-17]

In the completeness of their care, nursing involves the dimension of religion. Religion and spirituality, as requirements for nursing practice, are almost catechetical assumptions pervade the trajectory of nursing over the years and both pervade the thinking and make the profession.[18]

Religiosity and spirituality are constructs perceived in works ranging from the application of nursing theories to personal experiences. But all they enshrine religiosity and spirituality as requirements for professional practice.[19]

To highlight the need and the importance of caring for religious dimension, there is the NANDA (North American Nursing Diagnosis Association), which, being a nursing organization since 1982, seeks to validate and classify nursing diagnoses in the field of religiosity, such as "Willingness to improved religiosity"; "Religiosity impaired" and "impaired religiosity Risk."

Religiosity has shown potential impact on physical health, acting as a possible factor in preventing the development of disease in previously healthy people, any increase survival and impact on various diseases.[8] Recent studies show that people with higher religiosity have greater well-being, lower prevalence of depression, less abuse of illicit and licit drugs, lower incidence of suicide, better quality of life, longer survival and a shorter hospital stay, among other associations .[9]

Religiosity related to health has become paradigm to be established in clinical practice. Some health professionals are already waking up to this practice, both in the hospital and in public health. Practice says that "the nurse not only accounts for what is material in its attention to the patient, but a being that has life and suffering as a whole: body, mind and spirit." The nursing professional is thus able to make the patient learn to accept their situation, appease their suffering and meet their personal conflicts.[13]

Religion, spirituality and religiosity are evidenced in nursing care. However, there are still many dives to be taken to show the reflections of those in care practices and the organization of the profession.[19]

Considering what was mentioned earlier and the growing relevance of the theme, it is essential to carry out more studies in our country. There is still knowledge gaps related to religion. Providing care to the religious dimension of people requires sensitivity, perception and knowledge. Therefore, it is essential that the health care area is aware and thus be enable to provide and expand care in the religious sphere, because only so if detect other needs that must be met, not to remain hidden or missing in the care process and, specifically, the patient-professional relationship. The inclusion, in the collection of patient data, systematic information on religious and spiritual dimension, seems to be an essential and innovative strategy to highlight the need and the importance of assistance to this dimension.

The objectives of this study were to identify the sociodemographic characteristics of the study participants; evaluate religiousness and relate the various biosocial characteristics with religiosity.

METHODS

This study was a quantitative approach and descriptive, analytical and cross-sectional. Participants were people both male as female, from 20 years of age and resident in Itajubá, MG. The final sample consisted of 600 people, including 309 women and 291 men, distributed proportionally according to gender, from the total of men and women living in Itajubá, MG. The criteria for stipulating the size of the sample took into account that the greater their size, the more it tends to be representative.[20] The sampling was non probabilistic type by quotas (gender and age).

The following inclusion criteria were adopted: take part in the study; be able to communicate verbally and not carrying cognitive disorders.

As for the data collection procedures, interviews were scheduled in advance by personal contact and by phone. They were held in various districts of the city and, specifically, in the homes of participants. The data collection technique was a direct structured interview. The period of the interviews was from March to October 2010.

The proposed study was approved by the Research Ethics Committee (CEP) of the Wenceslau Braz Nursing School, Itajubá, MG, under Protocol No 266/2009. As this is research involving human subjects, the methodological procedures complied with the Declaration of Helsinki and the rules established by Resolution 196/96, of 10/10/96 and n. 251, 08.07.97.

For data collection, the following instruments were used:

1- Personal, Family, Social, Economic and Health characterization: prepared by the author of this study, intended to obtain gender-related data, age, marital status, education, religious practice, job, salary, health information and disease among others.

2- Portuguese version of the Duke Religiosity Scale (P-DUREL): it has five items scored from one to five that capture three of the religiosity dimensions that most relate to health outcomes: 1) organizational (RO, item 1): frequency to religious gatherings (masses, cults, religious ceremonies, study groups and prayer); 2) not organizational (RNO, item 2): frequency of private religious activities (prayers, meditation, reading religious texts, listen to or watch religious programs on TV or radio) and 3) intrinsic religiosity (RI, items 3 a 5): It refers to the search for internalization and full religiosity experience as the main objective of the person; the immediate purposes are considered secondary and achieved in harmony with basic religious principles.[21] The lower scores indicate greater agreement with these dimensions. Thus, to obtain the RO levels, RNO and RI scores should be reversed.[21] In the analysis of DUREL results, scores of the three dimensions (RO, RNO and RI) must be analyzed separately, and the scores of these three dimensions should not be combined into a total score.[22] In 2008, a group of researchers culturally adapted the original version of DUREL (P-DUREL) for use in Brazil.[23] In 2010, this instrument was validated in a low-income sample, the inhabitants lived on the outskirts of São Paulo. In 2012, a group of researchers from the Federal University of Ceará again validated this scale with university students in the health area of the mentioned University and psychiatric patients Psychiatry General Outpatient clinic of a university hospital in Fortaleza, Ceará.[21]

The record of results occurred in database using spreadsheet and analyzed statistically using the Statistical Package for the Social Sciences (version 15.0). In this study, the following statistical methods were used. Descriptive statistics: absolute and relative frequency, as well as the central tendency and dispersion measurements. Of inferential statistics: X2 test (chi-square), to investigate statistical significance between categorical variables; Student t test for comparison between sociodemographic variables and P-DUREL; Analysis of Variance (ANOVA) was used to compare the ages and the time to be patient with chronic disease with P-DUREL. To use this test, it was found that the variances were homogeneous among the categories; when there was no homogeneity of variances it was made fit through Brown Forsythe test. It was used Cronbach's alpha to assess the internal consistency of the scale was used and the criterion of significance of $p < 0.05$.

RESULTS AND DISCUSSION

It was found that 51.5% of study participants were male; the average age was 43 years (SD = 16.5); 33.2% had incomplete primary education; 52.7% were married; 66.2% lived in nuclear family; 73.8% had children and the average number of children was 3.1 (SD = 2.3) per family; 67.8% had a job, regardless of its nature (employee, working on their own, unpaid activity and domestic skills). The average income was R $ 652.00 per month (SD = 174.3) and, on average, 3.8 people (SD = 1.7) lived with that family income; 34.5% considered their "good" health; to compare their health status with the previous year, 55.2% classified it as "same" and when compared with others of their age, 39.3% said it was "better"; 67.8% were patients with a chronic disease; 56.7% did not practice physical exercise; 90.5% professed a religion and 61% were Catholic. Further data are presented in the following tables. (Tables: 1,2,3,4 and 5)

The scale reliability analysis was verified for the total items, considering a significance level of 5%. The value of alpha Crombach with all items (RI) was alpha = 0.747.

Regarding religious practice, the vast majority of respondents claimed to be adept at certain religion and the Catholic religion was the most indicated among others. These data coincide with the results of a work, which showed a high level of religious involvement in the Brazilian population: 95% had a religion, 83% considered the religion very important and 70% said they were Catholic.[3] The trend towards religiosity of the Brazilian people is clear in the large proportion of people who follow some kind of religion or doctrine (92.74% of the population). This shows the great diversity of religious traditions in Brazil (Gallup, 2013). Among Brazilians, the Roman Catholic Church had, in 2000, about 124 976 912 adherents, which corresponded to 73.60% when compared with the other religions.[25]

It was found that 44.8% attended religious services at least once a week. This finding was superior to the study conducted in 143 Brazilian cities and consists of 3007 respondents, of which 37% attended religious meetings once a week[3], as well as research conducted in the United States, where 30% of respondents in 2012 attended at least once a week religious celebrations.

Regarding the dedication of time to individual religious activities, 42.5% of respondents confirmed to accomplish

Table 1 - Organizational and Not Organizational Religiousness, and intrinsic P-DUREL scale referring to the study participants. Itajubá, MG, 2010 (n = 600)

Organizational Religiousness (RO):		
How often do you go to a church, temple or other religious meeting?		
	n	%
More than once a week	155	25,8
Once a week	174	29
Two to three times per month	95	15,8
A few times a year	112	18,7
Once a year or less	37	6,2
Never	27	4,5
No Organizational Religiousness (RNO):		
How often do you dedicate your time to individual religious activities such as prayers, prayers, etc.?		
	n	%
More than once a day	176	29,3
Daily	255	42,5
Two or more times a week	45	7,5
Once a week	30	5
A few times a month	42	7
Rarely or never	52	8,7
Intrinsic Religiosity (RI):		
1-In my life, I feel the presence of God (or the Holy Spirit).		
	n	%
Totally true for me	444	74
In general it is true	128	21,3
I'm not sure	18	3
In general it is not true	1	0,2
It is not true	9	1,5
2-My religious beliefs are really behind all my way of living.		
	n	%
Totally true for me	342	57
In general it is true	179	29,8
I'm not sure	46	7,7
In general it is not true	17	2,8
It is not true	16	2,7
3-I struggle so much to live my religion in all aspects of life.		
	n	%
Totally true for me	303	50,5
In general it is true	173	28,8
I'm not sure	68	11,3
In general it is not true	26	4,3
It is not true	30	5

Table 2 - Comparison between male and female study participants with RO, RNO domains and RI scale P-DUREL. Itajubá, MG, 2010 (n = 600)

RO and RNO domains		*Gender*				*p-value*
		Male		*Female*		
		n	%	n	%	
Domain RO	More than once a week	68	23,40	87,00	28,20	<0,004*
	Once a week	76	26,10	98,00	31,70	
	Two to three times per month	39	13,40	56,00	18,10	
	A few times a year	66	22.7	46,00	14,90	
	Once a year or less	25	8,60	12,00	3,90	
	Never	17	5,80	10,00	3,20	
Domain RNO	More than once a day	65	22,30	111,00	35,90	< 0,001*
	Daily	130	44,70	125,00	40,50	
	Two or more times a week	18	6,20	27,00	8,70	
	Once a week	18	6,20	12,00	3,90	
	A few times a month	25	8,60	17,00	5,50	
	Rarely or never	35	12,00	17,00	5,50	

Domain RI	(3 to 15 points)		***Gender***		
			Male	*Female*	
		N	*291*	*309*	<0,001**
		Average	*5,2*	*4,5*	
		Median	*5*	*4*	
		Standard deviation	*2,5*	*1,9*	
		Minimum	*3*	*3*	
		Maximum	*15*	*15*	

Table 3 - Comparison of education of study participants with domain RO, RNO and RI scale P-DUREL. Itajubá, MG, 2010 (n = 600)

		Education														*p-value*
		Nc Educatior		Educatic r Complete primar		Educatic r Incomplete primar		Complete High School - Scientific, technical or equivalen		High School Incomplete - scientific, technical or equivalen		Complete Higher Educatior		Higher Education Incomplete		
		n	*%*	*n*	*%*	*n*	*%*	*n*	*%*	*n*	*%*	*N*	*%*	*n*	*%*	
P-Durel (RO Dominium)	More than once a week	5	22,7	15	24,2	63	31,7	41	26,6	8	18	13	25	10	15,2	0,083**
	Once a week	11	50	20	32,3	48	24,1	44	28,6	11	25	18	34,6	22	33,3	
	Two to three times per month	2	9,10%	7	11,3	38	19,1	24	15,6	3	6,8	5	9,6	16	25,2	
	A few times a year	3	13,6	16	25,8	27	13,6	30	19,5	14	32	10	19,2	11	16,7	
	Once a year or less	1	4,5	3	4,8	14	7	10	6,5	5	11	2	3,8	2	3	
	Never	-	-	1	1,6	9	4,5	5	3,2	3	6,8	4	7,7	5	7,6	

		Education														p-value
		Nc Educatior		Educatic r Complete primar		Educatic r Incomplete primar		Complete High School - Scientific, technical or equivalen		High School Incomplete - scientific, technical or equivalen		Complete Higher Educatior		Higher Education Incomplete		
		n	%	n	%	n	%	n	%	n	%	N	%	n	%	
P-Durel (RO Dominium)	More than once a week	5	22,7	15	24,2	63	31,7	41	26,6	8	18	13	25	10	15,2	0,083**
	Once a week	11	50	20	32,3	48	24,1	44	28,6	11	25	18	34,6	22	33,3	
	Two to three times per month	2	9,10%	7	11,3	38	19,1	24	15,6	3	6,8	5	9,6	16	25,2	
	A few times a year	3	13,6	16	25,8	27	13,6	30	19,5	14	32	10	19,2	11	16,7	
	Once a year or less	1	4,5	3	4,8	14	7	10	6,5	5	11	2	3,8	2	3	
	Nunca	-	-	1	1,6	9	4,5	5	3,2	3	6,8	4	7,7	5	7,6	
P-Durel (RNO Dominium)	More than once a day	13	59,1	13	21	78	39,2	40	26	12	27	6	11,5	14	21,2	0,001*
	Daily	5	22,7	32	51,6	84	42,2	64	41,6	15	34	26	50	29	43,9	
	Two to three times a week	3	13,6	3	4,8	13	6,5	14	9,1	5	11	4	7,7	3	4,5	
	Once a week	-	-	3	4,8	5	2,5	9	5,8	1	2,3	6	11,5	5	7,6	
	Few times a month	-	-	6	9,7	9	4,5	12	7,8	2	4,5	5	9,6	8	12,1	
	Rarelly or never	1	4,5	5	8,1	10	5	15	9,7	9	21	5	9,6	7	10,6	

Table 4 - Relation of religious practice of the study participants with the RO and RNO dimensions, and RI P-DUREL. Itajubá, MG, 2010 (n = 600)

		Practice some religoin				p-value
		Yes		No		
		N	%	n	%	
P-Durel (RO Dominium)	More than once a week	155	28,5	-	-	<0,001*
	Once a week	173	31,9	1	1,8	
	Two to three times a week	91	16,8	3	5,5	
	A few times a year	90	16,6	21	38	
	Once a year or less	25	4,6	12	22	
	Never	9	1,7	18	33	
P-Durel (RNO Dominium)	More than once a day	172	31,7	4	7,3	<0,001*
	Daily	237	43,6	17	31	
	Two to three times a week	35	6,4	10	18	
	Once a week	30	5,5	-	-	
	Few times a month	37	6,8	4	7,3	
	Never	32	5,9	20	36	

RI Dominium	Religion		*p*- value
(3 to 15 points)	YES	NO	
FA	543	55	
Average	4,55	7,56	
Median	4	7	
Standard deviation	1,93	3,35	<0,001**
Minimum value	3	3	
maximum value	15	15	

Table 5 - Relation of age of the study participants with the RO and RNO domains,and RI scale P-DUREL. Itajubá, MG, 2010 (n = 600)

		Age														*p-value*
		20 to 29 years old		*30 to 39 years old*		*40 to 49 years old*		*50 to 59 years old*		*60 to 69 years old*		*70 to 79 years old*		*80 years old or more*		
		n	*%*	*n*	*%*	*n*	*%*	*n*	*%*	*n*	*%*	*n*	*%*	*n*	*%*	
P-Durel (RO Dominium)	More than once a week	30	20	25	19,8	29	24,2	30	32	26	47	13	39	2	11,1	0,012*
	Once a week	38	25	38	30,2	42	35	25	27	11	20	11	33	9	50	
	Two to three times a month	31	20	22	17,5	16	13,3	12	13	8	15	3	9,1	3	16,7	
	few times a year	35	23	21	16,7	20	16,7	22	23	8	15	4	12	2	11,1	
	Once a year or less	10	6,5	15	11,9	6	5	3	3,2	1	1,8	1	3	1	5,6	
	Never	10	6,5	5	4	7	5,8	2	2,1	1	1,8	1	3	1	5,6	
P-Durel (RNO Dominium)	More than once a day	18	12	37	29,4	31	25,8	33	35	29	53	17	52	11	61,1	<0,001*
	Daily	60	39	57	45,2	55	45,8	44	47	20	36	12	36	7	38,9	
	Two to three times a week	14	9,1	7	5,6	13	10,8	7	7,4	3	5,5	1	3	-	-	
	Once a week	11	7,1	6	4,8	7	5,8	4	4,3	1	1,8	1	3	-	-	
	Few times a month	24	16	9	7,1	4	3,3	3	3,2	-	-	2	6,1	-	-	
	Rarelly or never	27	18	10	7,9	10	8,3	3	3,2	2	3,6	-	-	-	-	

RI Dominium (3 to 15 points)	Age							*p* -value
	20 to 29 years old	30 to 39 yea	40 to 49 years old	50 to 59 years old	60 to 69 ye	70 to 79 years old	80 years old or more	ANOVA
N	154	126	120	94	55	33	18	<0,001**
Average	5,72	5	4,76	4,23	4	4,03	3,39	(BF)[1]
Median	5	5	4	3	3	3	3	
Standard deviation	2,65	2,3	2,03	1,93	2	1,45	0,85	
Minimum value	3	3	3	3	3	3	3	
Maximum value	15	15	11	15	10	9	6	

it through the daily frequency. These data are confirmed with the work entitled "Relationship between spiritual beliefs/religious and spiritual well-being of the nursing team" when they found that 59.9% of nursing members said they devoted their time to prayers, reading Bible and other activities daily.[27] Regarding RI, in relation to the item "I feel the presence of God (or the Holy Spirit) in my life", 74% reported being completely true to you; With respect to item "My religious beliefs are really behind all my way of life", 57% said that it was entirely true to them; and in "I try so hard to live my religion in all aspects of my life", the participants confirmed to be completely true to himself/herself were 50.5%. These data are corroborated with the study of two researchers[28], when obtained, in relation to the IR, the three items regarding religious beliefs or experiences and it was asked to answer how each item applies to the respondent. In "In my life, I feel the presence of God (or Spirit)," 90% reported being "completely true". The following item: "My religious beliefs are really behind all my way of living," "completely true" was the option chosen by 87% of respondents. In the third item, "I struggle so much to live my religion in all aspects of life", 43% answered "absolutely true."

When interpreting RO, RNO and IR compared with the level of education, it was found that there was no statistical significance for the first area, which did not happen to refer to the RNO and RI, as the data showed that the lower the level of education (unschooled and fundamental complete), the better religiosity. These data coincide with a survey on religion and age in which education with less than four years and four to seven years had better religiosity.[29]

The previous work can be confirmed with an exploratory Flowchart of religious transit occurred in Brazil in recent decades. The distribution of persons by level of education according to current religion has shown that incomplete elementary level was retained to higher proportions of supporters that, with the exception of Kardecists, were reduced as increasing the level of education.[30]

The results also showed that older people in relation to youth and adults were more religious. For most elderly, religion is something very important. Study showed that 75% of American elderly, religion was very important while among young people and adults, this figure was lower (44%). This may be related to the approaching end of life and the search for answers and emotional support that often are found in religions or beliefs.

It appears that the importance attached to religion increases with advancing age. Research has shown that 70% of older people referred to the increase in their

religiosity with age, reflecting their personal growth and significant event in their lives or even change of religion.

Religiosity is also a cultural phenomenon that emerges in different ways for different cohorts. Thus, the current elderly are more religious than young people because it developed in a context in which it was more normative to have and profess a religion than today. High levels of religiosity are often associated with older age. With advancing age, religion comes to represent an important source of support or emotional support that reflected a significant and positive effect on the mental and physical health of the elderly.

Most respondents who practiced a religion claimed that attended the church or house of worship once a week and those who did not practice any religion attended religious meetings a few times a year or never attended church.

A possible explanation for the previous data may be related to some factors, such as cultural, the way the churches or temples, for most religious people, is weekly, in order to participate in religious worship or Sunday Mass. Associated with this, the average age of study participants was 43 years, which is in line with the productive life of the people who worked all week, leaving them Sunday to dedicate themselves to religious activities. The fact that people did not practice religion and would sometimes go to religious meetings during the year may be related to religious rites with a social connotation, such as marriage, graduations, baptisms and other, not having the systematic commitment of religious participation.

Regarding the non-organizational religiosity, people who practiced a religion devoted themselves daily to read the Bible and religious books were prayers and did meditation, watched religious programs and church services, for example, on television, and practiced other religious activities. People who said they had no religious practice was positioned in two extreme strands, or never performed these activities or performed daily. This means that, while not participated in a particular religion, individually dedicated to some religious in nature activities, according to their personal beliefs, needs, culture, welfare and ideology. This aspect coincides with a study, when he mentions that non-organizational religiosity is to pray, read books, watch religious programs on television, whether or not adept at particular religion.[31]

People who practiced certain religion had better intrinsic religiosity than those who did not practice. Whereas the intrinsic religiosity refers to search internalization and full of religious experience as the main objective of the person, it can be inferred that to practice a certain religion is a strategy to better highlight religiosity.

It was found that women give more importance to religion than men. This can be understood by observing strong involvement with the religion they belong to. For example, the activities of the parishes, where people generally assume leadership, there are different forms of membership and link to the genres in many Pentecostal churches and such differences are directly related to the ideological and cultural pattern of femininity and masculinity in social context.[30]

In a study of religious involvement of the population and the relationship with sociodemographic variables, it was found that women had greater religious involvement than men (Moreira-Almeida, 2010). The exploratory Flowchart of religious transit in Brazil, developed in 2001, showed that with the exception of Protestantism history, women had become more religious than men.[30]

A possible explanation for this occurrence may be related to the fact that the woman, until then, are more involved with the issues and problems confronting the family, being a family caregiver. It can be inferred that these situations lead women to seek religious support to face and overcome the various difficulties encountered and experienced in the family.

CONCLUSION

Through this study, we identified religious evidence among the study participants. Religious involvement was in organizational religiosity, not organizational and intrinsic.

The sociodemographic factors age, gender and education significantly interfered with the religion. The more advanced the age, the higher were the levels of religiosity; females, compared to males, showed better religiosity and inversely occurred with schooling, that is, the lower the number of years of study, the greater the religious evidence, which needs more studies.

The act of practicing a religion showed significant differences when compared to the absence of religious practice in relation to three types of religiosity.

It is recommended that further studies of this nature are carried out in other locations and with larger samples to confirm and consolidate these data are still relatively new in the field of religion and that need to be explored further. It is also recommended that religion is studied by different areas of human knowledge mainly by health sciences, considering that this phenomenon is an important factor in the health/disease process. This is important to broaden the understanding of the construct and discussing the issue in the national literature, therefore, the main limitation in this study was the scarce national publication. It is suggested that religion is studied with a gender perspective, age and health professionals.

The results of this study will support the nursing care in relation to the religious dimension, as they may provide essential elements to nurses to realize the need of

religious assistance and provide scientific emplacements in the systematization of nursing care.

The knowledge gained can also support and direct intervention of nurses in the care process, offering greater visibility in relation to the biopsychosocial and spiritual needs and, above all, being religious cared and thus committing to it.

Finally, the study of religion is a sense of strategy and understanding that the invisible can become visible, needing to do so, not only scientific but also sensitivity and humanizing elements that deserve assist in nursing and also the performance other health professionals.

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