RELIGIOSITY AND LIFESTYLE OF AN ADULT POPULATION

Religiosidade e estilo de vida de uma população adulta

Religiosidad y estilo de vida de una población adulta

Original Article

Marli Rosangela Cres[(1)]
Gina Andrade Abdala[(1)]
Maria Dyrce Dias Meira[(1)]
Carlos Antonio Teixeira[(1)]
Maria Fernanda Melo Lopes Ninahuaman[(1)]
Maria Cecília Leite de Moraes[(1)]

1) Adventist University Center of São Paulo (*Centro Universitário Adventista de São Paulo – UNASP*) - São Paulo (SP) - Brazil

ABSTRACT

Objective: to characterize the profile of religiosity and lifestyle of an adult population and to analyze the association between these variables. **Methods:** Quantitative descriptive cross-sectional research conducted with participants (n=206) of two Health Fairs held in the city of São Paulo on October, 10th 2013 and May, 4th 2014. Two questionnaires were applied, The Duke University Religion Index (DUREL, subdivided into the dimensions Organizational, Non-organizational and Intrinsic Religiosity) and the FANTASTIC Lifestyle Assessment. Spearman's Rho test was performed to associate the variables "lifestyle" and "religiosity", and the chi-squared test was used for the bivariate analysis between sex and religiosity. **Results:** We found a mostly good religiosity profile in the three dimensions, particularly the Intrinsic Religiosity, which reached 83.5% (n=167) in the three questions. As to lifestyle (FANTASTIC), the following rating was obtained: 26.6% (n=34) "Good", 48.4% (n=62) "Very Good", and 12.5% (n=16) "Excellent". Of the 125 bivariate analysis, 13 (11.3%) presented a weak ($\rho<0.30$), however significant ($p< 0.05$), correlation. In the chi-squared associations, religiosity was related to lifestyle dimensions regarding the use of alcohol and drugs, balanced diet and mental health. **Conclusion:** The study population's religiosity, considering the three dimensions analyzed, was characterized as "good" and "very good"; and the lifestyle, according to the total score of the FANTASTIC assessment, could be considered healthy. Although weak, there was an association between religiosity and lifestyle.

Descriptors: Religion; Spirituality; Life Style; Health Promotion.

RESUMO

Objetivo: *Caracterizar o perfil de religiosidade e estilo de vida de uma população adulta e analisar a associação entre essas variáveis.* **Métodos:** *Pesquisa descritiva, transversal e quantitativa, realizada com participantes (n=206) de duas Feiras de Saúde na cidade de São Paulo, em 20/10/2013 e 04/05/2014. Aplicaram-se dois instrumentos, o Duke University Religion Index (DUREL, subdividido nas dimensões Religiosidade Organizacional, Não Organizacional e Intrínseca) e o Estilo de Vida FANTÁSTICO. Realizaram-se os testes Rho de Spearman para associação das variáveis "estilo de vida" e "religiosidade", e Qui-Quadrado para análise bivariada entre sexo e religiosidade.* **Resultados:** *Encontrou-se perfil de religiosidade predominantemente bom nas três dimensões, com destaque para a Religiosidade Intrínseca, que alcançou 83,5% (n=167) nos três quesitos. Quanto ao estilo de vida (FANTÁSTICO), obteve-se a classificação de: 26,6% (n=34) "Bom", 48,4% (n=62) "Muito Bom" e 12,5% (n=16) "Excelente". Das 125 análises bivariadas, 13 (11,3%) apresentaram correlação fraca (ρ< 0,30), porém significativa (p<0,05). Nas associações do Qui-Quadrado, a religiosidade se relacionou às dimensões do estilo de vida quanto ao uso de álcool e drogas, alimentação equilibrada e saúde mental.* **Conclusão:** *A religiosidade na população estudada, considerando-se as três dimensões analisadas, caracterizou-se como "boa" e "muito boa"; e o estilo de vida, segundo escore total do questionário FANTÁSTICO, pôde ser considerado saudável. Apesar de fraca, confirmou-se associação entre a religiosidade e o estilo de vida.*

Descritores: *Religião; Espiritualidade; Estilo de Vida; Promoção da Saúde.*

Received on: *04/23/2015*
Revised on: *05/04/2015*
Accepted on: *06/15/2015*

RESUMEN

Objetivo: *Caracterizar el perfil de religiosidad y estilo de vida de una población adulta y analizar la asociación entre esas variables.* **Métodos:** *Investigación descriptiva, transversal y cuantitativa realizada con participantes (n=206) de dos Ferias de Salud de la ciudad de São Paulo en 20/10/2013 y 04/05/2014. Se aplicaron dos instrumentos, el Duke University Religion Index (DUREL, subdividido en las dimensiones Religiosidad Organizacional, No Organizacional e Intrínseca) y el Estilo de Vida FANTÁSTICO. Se realizaron las pruebas Rho de Spearman para la asociación de las variables "estilo de vida" y "religiosidad", y el Cui-Cuadrado para el análisis bivariado entre el sexo y la religiosidad.* **Resultados:** *Se encontró el perfil de religiosidad en su mayoría bueno para las tres dimensiones en especial para la Religiosidad Intrínseca que alcanzo el 83,5% (n=167) en las tres cuestiones. Respecto el estilo de vida (FANTÁSTICO) se obtuvo la clasificación de: 26,6% (n=34) "Bueno", 48,4% (n=62) "Muy Bueno" y el 12,5% (n=16) "Excelente". De los 125 análisis bivariados, 13 (11,3%) presentaron correlación débil (ρ< 0,30) pero significativa (p<0,05). En las asociaciones del Chi-Cuadrado, la religiosidad se relacionó con las dimensiones del estilo de vida en cuanto al uso del alcohol y drogas, alimentación equilibrada y salud mental.* **Conclusión:** *Al considerar las tres dimensiones analizadas, la religiosidad de la población estudiada se caracterizó como "buena" y "muy buena"; y según la puntuación total del cuestionario FANTÁSTICO, el estilo de vida fue considerado saludable. Aunque débil, se confirmó la asociación de la religiosidad y el estilo de vida.*

Descriptores: *Religión; Espiritualidad; Estilo de Vida; Promoción de la Salud.*

INTRODUCTION

The search for the meaning of life and the transcendent is one of the human needs that, even when latent, must be considered in the context of general health. Religiosity and spirituality have been increasingly addressed in the academic context, with important strategies to face adverse situations related to the health-disease process and its determinants, including the health lifestyle[1].

In the present study, we elected the concept of religiosity as the representation of a belief and practices based on a certain religion, and spirituality as the individual characteristics that determine the individual's connection with the universe and other beings, which may or may not be related to the belief in a "God"[2].

Intellectuals and scientists predicted that religiosity would disappear or decrease throughout the twentieth century, but what happened was an increased interest of researchers in the theme of religiosity and spirituality revealed by the increasing number of publications, including high-impact journals, both in developed and developing countries[3-6].

Even in a so-called secularized world that excludes religion as an important aspect of life the religious practice is present, varying, however, from country to country. In the United States of America (USA), for example, 89% of the population has a religion, and 31% attend religious services at least once a week. In Europe, the average of the population who attends religious services is 31.6%, varying among countries. A study of 35 countries, which did not include Brazil, the USA and Europe, found that 87.8% of the respondents reported belonging to a religious denomination and 41.9% reported attending the service at least once a week[3].

Considering the difference between religiosity and spirituality, the objective and measurable characteristic of religiosity should be highlighted, as it represents the practice of a public or private religion. For this reason, one should say that in research involving the two themes, religiosity is the one which may present a relationship/association with the lifestyle of individuals[4,5].

Religiosity is an intrinsic component of the identity of the Brazilian people, which can be confirmed in a study with a sample of 3,007 people (2,346 adults and 661 adolescents) in 143 cities, in which 95% reported having a religion, 83% considered religion very important and 37% attended a religious service at least once a week[3].

In this sense, it is noteworthy that religion is part and is still present in contemporary man, influencing other dimensions and affecting their health, as this is understood not only as the biopsychosocial well-being, but also the spiritual. The inclusion of the spiritual dimension is gaining ground and meaning to the extent that the World Health Organization (WHO) assumes its incorporation in official documents that aim to investigate the parameters of quality of life, as seen in the WHOQOL-Bref and WHOQOL-SRPB instruments[7].

The theoretical framework of Religiosity adopted defines it as a practice involving a religious activity that can be Organizational (OR, participation in groups of religious services), Non-organizational (NOR, practiced alone, and includes: to communicate with God, meditate, read religious writings, watch/listen to religious media or perform private religious rituals) and Intrinsic religiosity (IR, which refers to the search for internalization and full experience of religiosity as the main objective of the individual)[8].

One of the authors investigating this issue reports 267 original papers and literature reviews relating religion and health, which show evidence of how religiosity improves satisfaction with life, reduces delinquent behavior, increases CD4 cells (T helper cells), decreases cortisol, decreases

interleukin, increases longevity, lower the rates of stroke and hypertension, and increases the people's chances of adhering to physical activity[4].

Articles published in Brazil present studies that highlight the importance of the relationship between health and religion in the country. It was observed that religiosity in Brazil has been present also in recent studies addressing mental health. The results of these studies indicate that Brazilians, in general, find support in religion for coping with stressful situations[9-13].

Considering the evidence of a positive relationship between religiosity and health, it is questionable whether there is an association between religiosity and health lifestyle, given that lifestyle is defined as a set of habitual actions that reflect attitudes, values and opportunities in people's lives. Based on this definition, it is possible to say that if the habits reflect the values, they may also be associated with aspects of religion[14].

On the other hand, it can also be inferred that no one is entirely healthy, that is, none one has the maximum degree of health recommended by the WHO definition, which refers to health as a total well-being. This concept of health, though understood as something utopian, guides one way to go and can be facilitated by religiosity, which has been identified as a predictor of habits that are part of a healthy lifestyle[15-22].

The present study assumes that a relevant aspect to be worked in health care is the healthy lifestyle, not only through information and guidance, but also taking into consideration how or what makes it difficult to change health habits, with religiosity being a facilitator of this process. Given health as the biopsychosocial-spiritual well-being, health enhancing should involve the practice of healthy physical, social, emotional, environmental, educational and spiritual habits[23-25]. To improve the spiritual health, one should practice healthy spiritual habits, and this practice is what is considered religiosity. Based on the above, the objective of the present study was to characterize the profile of religiosity and lifestyle of an adult population and to analyze the association between these variables.

METHODS

This is a quantitative descriptive cross-sectional[26] field research carried out in two educational events in the format of "Health Fair" promoted by the *Centro Universitário Adventista de São Paulo - UNASP/SP* (Adventist University Center of Sao Paulo) in two consecutive years (10/20/2013 and 05/04/2014). The events took place in the central area for public exhibitions of a shopping center in the southern region of the city of São Paulo, SP. The convenience and spontaneous sample (n=206) involved shopping bystanders who participated in the two Health Fairs. Due to the logistics of the Health Fair at the first event, with the participation of 70 adults, the second event was planned to last longer in order to increase the number (n) of participants, which resulted in the participation of over 136 participants.

The participants who accepted the invitation to participate in the study should first sign a Free Informed Consent Form (IC) that was placed in an exclusive box to ensure anonymity. Six researchers trained for the procedure filled in the printed questionnaires identified with sequential numeric codes. The inclusion criteria were: adults (of both genders) and age 18-59; those who were unable to respond to the questionnaires were excluded, although they could normally participate in the Health Fair.

The study addressed areas related to religiosity, healthy lifestyle, self-reported health and sociodemographic data (age, gender, education and marital status), as well as religious affiliation. Only those who met the inclusion criteria were included in the research.

The Duke University Religion Index (DUREL) [2], validated in Brazil[7], and the FANTASTIC Lifestyle Assessment[27] were used. The Duke Religiosity Index (DUREL) is a five-item scale developed at the Duke University to measure three main dimensions of religious involvement: Organizational Religiosity (OR, frequency to religious meetings); Non-organizational Religiosity (NOR, frequency of private religious activities); and Intrinsic Religiosity (IR, with 3 items: IR 1, IR 2, IR 3, which is the pursuit of internalization and full experience of religiosity[2].

The FANTASTIC Lifestyle Assessment, validated in Brazil[27], contains 25 close-ended questions divided into nine domains (family and friends; activities; nutrition; tobacco and toxics; alcohol; sleep; seat belt; stress and safe sex; type of behavior, insight, and career). This instrument has 23 questions with five response choices and two dichotomous (yes or no) questions. The alternatives are placed in an increasingly order in relation to healthy lifestyle (with values from zero to four). The sum of the values obtained in the results of the responses are classified into five categories: excellent (85-100), very good (70-84), good (55-69), fair (35-54), and needs to improvement (0-34)[27].

As some questions were not answered by the participants, the sample value differs in each variable in the tables.

The analysis of data was performed in the Statistical Package for Social Sciences (SPSS). The chi-squared test was used for the analyses of bivariate association between Religiosity (ordinal categorical) and Gender (dichotomous), and Spearman's Rho test was used to correlate Religiosity to the FANTASTIC lifestyle.

The study was authorized by the Research Ethics Committee of the *Centro Universitário Adventista de São Paulo – UNASP* (Adventist University Center of São Paulo) Opinions No. 415.406 and 572.966 approved on October 17, 2013 and March 28, 2014, respectively.

RESULTS

The analysis of the sociodemographic profile of the research participants found a mean age of 36.5 years (SD= 11.5), with age ranging 18-59 years. As to gender, women predominated in 67% (n= 138). With regard to education, 85.6% (n= 160) had more than eight years of education, and regarding marital status, 50.5% (n= 95) do not have a partner. There is a predominance of Protestants, with 45.8% (n= 93), and Catholics, with 37.9% (n= 78) compared to the others (Table I). It was also observed that among Protestants, 41% are Adventists (n= 38).

For the classification of the religiosity studied in the group of adult participants of this research according to the classification of the DUREL Index, the results are displayed as domains: OR (Organizational Religiosity), NOR (Non-organizational Religiosity) and IR (Intrinsic Religiosity, subdivided into: IR 1, IR 2, IR 3). For OR (how often one attends religious services), the results were as follows: 62% (n= 124) of adults assiduously attended religious services, including those who attend “more than once a week” and those who attend “up to once a week”.

With regard to NOR (the frequency of religious practices such as praying, reading the Bible and watching or listening to religious programs on the radio and TV), it was found that 70.5% (n= 141) of the individuals engage in these more personal practices, including those who do it “more than once a day” and those who do it “every day” (Table II).

Table I - Characterization of the study population according to gender, education, marital status, and self-reported religion and health (n= 206). São Paulo, SP, 2013 and 2014.

Characterization of the sample (n=206)	n	%
Gender (n= 206)		
Female	138	67.0
Male	33	33.0
Education (n= 187)		
1-3 years	6	3.2
4-7 years	21	11.2
8 or + years	160	85.6
Marital status (n= 188)		
With partner	93	49.5
Without partner	95	50.5
Self-reported religion (n= 203)		
Catholic	78	38.4
Protestant	93	45.8
None	14	7.0
Spiritist	9	4.4
Others (mormons, multiple religions, spiritualist)	9	4.4
Self-reported health (n= 199)		
Very good	13	6.5
Good	98	49.2
Fair	75	36.4
Bad	6	3.0
Very bad	5	2.5
Does not know	2	1.0

Table II - Distribution of sub-items of OR (Organizational Religiosity) and NOR (Non-organizational Religiosity) of the study participants (n=200). São Paulo, SP, 2013 and 2014.

Religiosity	**n**	**%**
OR (Organizational Religiosity = how often one attends religious services). n= 200		
More than 1 x a week	51	25.5
1 x a week	73	36.5
2-3 x a month	21	10.2
Some x a year	28	13.6
1 x a year or less	12	5.8
Never	15	7.3
(Non-organizational Religiosity = how often one spends time in private religious activities) n= 200		
More than 1 x a day	37	18.5
Daily	104	52
2 or + x a week	27	13.5
A few x a month	13	6.5
Rarely or never	19	9.5

Table III **-** Distribution of sub-items of Intrinsic Religiosity (IR1, IR2 and IR3) of adult study participants (n=200). São Paulo, SP, 2013 and 2014.

IR: Intrinsic Religiosity	**IR 1: experience the presence of God or the Holy Spirit (n=200)**		**IR 2: beliefs are what really lie behind my whole approach to life (n=200)**		**IR 3: try hard to carry religion over into all other dealings in life (n=200)**	
	N	**%**	**n**	**%**	**n**	**%**
Definitely true	172	86.0	132	66.0	117	58.5
Tends to be true	25	12.5	51	25.5	50	25.0
Unsure	1	0.5	8	4.0	15	7.5
Tends not to be true	0	0.0	4	2.0	6	3.0
Definitely not true	2	1.0	5	2.5	12	6.0

As to Intrinsic Religiosity (IR = the pursuit of internalization and full experience of religiosity), with regard to the three questions (IR 1 = feel the presence of God; IR 2 = beliefs are behind everything and; IR 3 = they strive to live the religion in all aspects), we found a percentage equal to or greater than 83.5% (n= 171 or more), including those who consider it “completely true” or “generally true” in the three questions (Table III).

In the analysis of bivariate association between Religiosity and Gender, the chi-squared test found statistically significant associations ($p< 0.05$) between gender and OR (X^2= 6.9), gender and NOR (X^2= 4.9), and gender and IR 1 (X^2= 6.18), i.e., religiosity was associated with female gender. No association was found between gender and IR 2 and/or IR 3.

When correlating (Spearman’s Rho) age, education and religiosity categories, it was found that age was positively related to OR (ρ= 0.156; p=0.027). On the other hand, education was inversely related to NOR (ρ= -0.189; p= 0.011).

As to the lifestyle profile, an analysis of the total score of the FANTASTIC Assessment, recoded from 0 to 100, found that 0.8% (n= 1) of this population “needs improvement” in

Table IV - Spearman's Rho correlation between FANTASTIC lifestyle, OR (organizational religiosity = how often one attends religious services) and NOR (non-organizational religiosity = how often one spends time in private religious activities) (n=206). São Paulo, SP, 2013 and 2014.

Questions	**FANTASTIC**	**OR (attendance to religious services)**		**NOR (private religious activities)**	
		ρ	**ρ**	**ρ**	**ρ**
I have someone to talk to	1				
I give and receive affection	2				
I am vigorously active	3				
I am moderately active	4				
Balance diet	5			-0.175	0.013
I eat excess	6				
I am above the normal range of my ideal weight	7				
I use tobacco	8	-0.250	0.001		
I over use prescribed or "over the counter" drugs	10				
I drink caffeine	11	-0.163	0.023		
Average alcohol intake per week	12	-0.185	0.013		
I drink more than 4 drinks on an occasion	13	-0.243	0.001		
I sleep well	15				
I use seatbelts	16				
Stress	17				
I relax and enjoy leisure time	18				
Safe sex	19	-0.170	0.015		
I seem to be in a hurry	20				
I feel angry and hostile	21				
I am a positive thinker	22				
I feel tense	23				
I feel sad	24				
I am satisfied with my job	25				

ρ: Spearman's Rho; p: significance level<0.05.

lifestyle, 11.7% (n= 15) have a "fair" lifestyle, 26.6% (n= 34) "good", 48.4% (n= 62) "very good", and 12.5 (n= 16) "excellent".

The analysis of the correlation between Religiosity and the FANTASTIC lifestyle, using the Spearman's Rho test and a significance value of $p \leq 0.05$, found at least 13 correlations between religiosity variables and the 23 questions about lifestyle in the FANTASTIC Assessment. The two dichotomous questions were ignored (questions 9 and 14) in this analysis. The DUREL variables, as well as the FANTASTIC ones, analyzed separately, enabled a better use of the entire questionnaire (Tables IV and V).

Table V - Spearman's Rho correlation between FANTASTIC lifestyle and Intrinsic Religiosity (IR). IR 1 (feel the presence of God or the Holy Spirit), IR 2 (beliefs lie behind the whole approach to life), and IR 3 (try hard to carry religion over into all other dealings in life) (n=206).

Questions	FANTASTIC	IR 1: experience the presence of God or the Holy Spirit		IR 2: beliefs are what really lie behind my whole approach to life		IR 3: try hard to carry religion over into all other dealings in life	
		ρ	ρ	ρ	ρ	ρ	ρ
I have someone to talk to	1	-0.146	0.04				
I give and receive affection	2	-0.156	0.032				
I am vigorously active	3						
I am moderately active	4						
Balance diet	5						
I eat excess	6						
I am above the normal range of my ideal weight	7	0.148	**0.044**				
I use tobacco	8			-0.178	0.015		
I over use prescribed or "over the counter" drugs	10						
I drink caffeine	11						
Average alcohol intake per week	12						
I drink more than 4 drinks on an occasion	13					-0.186	**0.012**
I sleep well	15						
I use seatbelts	16						
Stress	17						
I relax and enjoy leisure time	18						
Safe sex	19						
I seem to be in a hurry	20						
I feel angry and hostile	21						
I am a positive thinker	22					-0.205	**0.004**
I feel tense	23						
I feel sad	24	-0.151	**0.034**				
I am satisfied with my job	25						

ρ (Spearman's Rho test) and p (significance level <0.05).

DISCUSSION

Among the specific objectives of the *Política Nacional de Promoção da Saúde – PNPS* (National Health Promotion Policy), two should be highlighted as they propose to stimulate innovative socially inclusive alternatives and enhance the use of public spaces, optimizing the development of health promotion activities. Embedded in these objectives is the challenge to involve all segments of society in the search for strategies to cope with the health needs of the population[28].

The Ministry of Health of Brazil proposed, in partnership with other Ministries, a plan of strategic actions for coping with Chronic Noncommunicable Diseases (NCDs) based on three axes, one of which is Health Promotion, which seeks, based on intersectionality, to overcome the determinants of the health-disease process by implementing actions to

encourage physical activity, healthy eating, measures to combat smoking and alcohol, and active aging[29].

The Health Fair used as an educational strategy of the present research is within the scope of the PNPS. At the same time, it becomes an instrument to attract people interested in knowing more about a healthy lifestyle with simple practices capable of promoting health in a comprehensive way.

The present study showed that there was an association between religiosity and gender, i.e., women are more involved with religiosity than men. There was also an association between religiosity and age ($p<0.05$). The findings were similar to the results of a study conducted in Itajubá with 600 adults over 20 years of age, whose profile of religiosity was good and associated with female gender and older people[30].

In the present study, there was an association between those who attend church/temples/groups and good lifestyle habits such as not smoking and drinking less alcohol. Adults who are more involved in religious services are less likely to use alcohol and drugs compared to people who attend less regularly or are affiliated with less conservative religious denominations, or those who have no affiliations[31].

Research conducted with 233 students in Bahia showed that religiosity can play a positive role in the cessation of drug use, abstinence or even decrease in the use of these substances[32].

Another positive association found in the present study relates to the lowest caffeine intake (coffee, tea and cola soft drinks) among all the participants from all religions. These findings were also present in a study conducted in the same southern region of São Paulo with 2,355 adults, showing a decrease in caffeine consumption among Adventists[33]. The precepts and practices encourage Adventists to abstain from the consumption of coffee, soft drinks and caffeinated teas; additionally, studies show that Adventists have lower prevalence of smoking alcohol consumption[34].

It was found in the present study a positive relationship between "safe sex" and Organizational Religiosity (OR = attending religious services). Another study revealed the same finding, showing that religious involvement was the strongest reason to avoid sex before marriage[35].

The Non-organizational Religiosity (NOR, demonstrated through daily private practice of religion) correlated to the balanced diet in this study. A similar association has been reported in the scientific literature in studies that analyzed the lifestyle adopted by Adventists. Individuals affiliated with this religious denomination avoid red meat and focus on the consumption of fruits, vegetables and nuts in the diet. These eating habits are part of religious beliefs adopted by these Protestants; however, the risks of mortality are not conclusive yet[36].

It is also noted in this study that the Intrinsic Religiosity, the IR 1 (feeling the presence of God), was related to "having someone to talk to and give and receive affection". The correlation coefficients of -0.146 and -0.156, respectively, may indicate that the intimate relationship with God, the sense of the sacred in life, as well as the emotions of giving and receiving affection will reflect in some domains of well-being: personal domain, relational, environmental and transcendental[37].

In this sense, this feeling of belonging that is consolidated in humanitarian relations also indicates the positive relationship that one can have with God or a higher being, understood as the Father, Creator, Almighty and Benevolent who cares and remembers his creation. On the other hand, this relationship may be negative when a person sees a punishing God who punishes and abandons his children[38]. In these circumstances, depressive feelings appear, exacerbating the mental health picture. Regarding the association between depression and Religiosity/ Spirituality (R/S), it is important to report that among the 178 studies considered to be of greater methodological rigor, 119 (67%) reported inverse relationships (the more involved with religion, the less depression) and 13[7%] found positive relationships to depression[39].

The associations between IR 2 (my religious beliefs are what really lie behind my whole approach to life), IR 3 (I try hard to carry my religion over into all other dealings in life) and the use of tobacco and alcohol in the present study revealed that the higher the intrinsic religious involvement, the lower the use of these substances. Religiosity is a protective factor for the use and abuse of harmful substances and can be an alternative to solve the problems of addicts in public health[32].

The association of IR 3 (I try hard to live up to my personal beliefs) and the "think positively" revealed statistically significant results in the present research. Faith and spirituality are resources that help cope with uncertainty, fear, discrimination, loneliness and pain, mobilizing vital energies, which can mean faith to religious individuals[40].

It can be said that in the present study the relationship between religiosity and lifestyle presented a prevalence of 11.3% (n= 13) of association, which although considered weak (coefficient <0.30), cannot be fully denied.

Among the limitations of this study is its design – for being a cross-sectional study, it precludes a causal relationship.

Furthermore, studies investigating this issue in the adult population are scarce. It is recommended that longitudinal

studies are conducted to deepen the understanding of this issue regarding the mechanisms of how religiosity can help in the adoption of a health promotion lifestyle. The importance of educational activities relating the dimensions of religiosity to lifestyle to promote health in a comprehensive way should be highlighted.

CONCLUSION

Religiosity in the study population, regarding the three dimensions analyzed, was characterized as "good" and "very good"; and lifestyle, according to the total score in the FANTASTIC assessment could be considered healthy. Although weak, there was an association between religiosity and lifestyle.

CONFLICTS OF INTEREST: There are no conflicts of interest in the present study.

REFERENCES

1. Lucchetti G, Lucchetti ALG, Puchalski CM. Spirituality in medical education: global reality? J Relig Health. 2012;51(1):3-19.
2. Koenig HG, Büssing A. The Duke University Religion Index (DUREL): a five-item measure for use in epidemiological studies. Religions. 2010;1(1):78-85.
3. Moreira-Almeida A, Pinsky I, Zaleski M, Laranjeira R. Envolvimento Religioso e Fatores Sociodemográficos: resultados de um levantamento nacional no Brasil. Rev Psiq Clín. 2010;37(1):12-5.
4. Koenig HG. Medicina, Religião e Saúde. Porto Alegre RS: L&PM; 2012. Religião e Saúde; p. 54-67 e Os Sistemas Imunológico e Endócrino; p. 82-95.
5. Reinert KG, Koenig HG. Re-examining definitions of spirituality in nursing research. J Adv Nurs. 2013;69(12):2622-34.
6. Lucchetti G, Lucchetti AL. Spirituality, religion, and health: over the last 15 years of field research (1999-2013). Int J Psychiatry Med. 2014;48(3)199-215.
7. Panzini RG, Maganha C, Rocha NS, Bandeira DR, Fleck MP. Validação brasileira do Instrumento de Qualidade de Vida/espiritualidade religião e crenças pessoais. Rev Saúde Pública. 2011;45(1):153-65.
8. Taunay TCD, Gondim FAA, Macedo DF, Moreira-Almeida A, Gurgel LA, Andrade LMS, et al. Validação da Versão Brasileira da Escala de Religiosidade de Duke (DUREL). Arch Clin Psychiatry (São Paulo). 2012;39(4):130-5.
9. Leite IS, Seminotti EP. A influência da Espiritualidade na Prática Clínica em Saúde Mental: uma revisão sistemática. Rev Bras Ciênc Saúde. 2013;17(2):189-96.
10. Santos NC, Abdala GA. Religiosidade e qualidade de vida relacionada à saúde dos idosos em um Município na Bahia, Brasil. Rev Bras Geriatr Gerontol. 2014;17(4):795-805.
11. Corrêa AAM, Moreira-Almeida A, Menezes PR, Vallada H, Scazufca M. Investigando o Papel do Suporte Social na Associação entre Religiosidade e Saúde Mental em Idosos de Baixa Renda: resultados do São Paulo Ageing & Health Study (SPAH). Rev Bras Psiquiatr. 2011;33(2):157-64.
12. Veras RM, Vieira JMF, Moraes FRRA. A Maternidade Prematura: o suporte emocional através da fé e religiosidade. Psicol Estud. 2010;15(2):325-33.
13. Rocha NS, Fleck MPA. Avaliação de qualidade de vida e importância dada a espiritualidade / religiosidade / crenças pessoais (SRPB) em adultos com e sem problemas crônicos de saúde. Rev Psiquiatr Clín. 2011;38(1):19-23.
14. Nahas MV, Barros MV, Francalacci V. O pentáculo do bem-estar, base conceitual para avaliação do estilo de vida de indivíduos ou grupos. Rev Bras Ativ Fís Saúde. 2000;5(2):48-59.
15. Santos ARM, Dabbicco P, Cartaxo HGO, Silva EAPC, Souza MRM, Freitas CMSM. Revisão Sistemática Acerca da Influência da Religiosidade na Adoção de Estilo de Vida ativo. Rev Bras Promoç Saúde. 2013;26(3):419-25.
16. Silva LBE, Silva SSBE, Marcilio AG, Pierin AMG. Prevalência de Hipertensão arterial em Adventistas Sétimo Dia da Capital e do interior paulista. Arq Bras Cardiol. 2012;98(4):329-7.
17. Backes DS, Backes MS, Medeiros HMF, Siqueira DF, Pereira SB, Dalcin CB, et al. Oficinas de espiritualidade: alternativa de cuidado para o tratamento de dependentes químicos integrante. Rev Esc Enferm USP. 2012;46(5):1254-9.
18. Barbosa Filho VC, Campos W, Lopes AS. Prevalence of alcohol and tobacco use among Brazilian adolescents: a systematic review. Rev Saúde Pública. 2012;46(5): 901-17.
19. Coutinho RZ, Miranda-Ribeiro P. Religião, religiosidade e iniciação sexual na adolescência e juventude: lições de uma revisão bibliográfica

sistemática de mais de meio século de pesquisas. Rev Bras Est Pop. 2014;31(2):333-65.

20. Moreira-Almeida A, Koenig HG, Lucchetti G. Clinical implications of spirituality to mental health: review of evidence and practical guidelines. Rev Bras Psiquiatr. 2014;36(2):176-82.

21. Souza LDM, Maragalhoni TC, Quinquoses MT, Jansen K, Cruzeiro ALS, Ores L, et al. Bem-estar Psicológico de Jovens de 18 a 24 anos: fatores associados. Cad Saúde Pública. 2012;28(6):1167-74.

22. Rodrigues JSM, Ramdohr Sobrinho EC, Toledo MLV, Zerbetto SR, Ferreira NMLA. O atendimento por instituição pública de saúde: percepção de famílias de doentes com câncer. Saúde Debate. 2013;37(97):270-80.

23. Buss PM, Pellegrini Filho A. A Saúde e seus Determinantes Sociais. Physis (Rio J). 2007;17(1): 77-93.

24. Maselko J, Hughes C, Cheney R. Religious social capital: its measurement and utility in the study of social determinants of health. Soc Sci Med. 2011;73(5): 759-67.

25. Santos DS, Tenório EA, Brêda MZ, Mishima SM. Processo saúde/doença e estratégia de saúde da família: o olhar do usuário. Rev Latinoam Enferm. 2014;22(6):918-25.

26. Polit DF, Beck CT. Fundamentos de Pesquisa em Enfermagem: avaliação de evidências para a prática de enfermagem. 7ª ed. Trad. Regina Denise de Sales. Porto Alegre: Artmed; 2011.

27. Silva AMM, Brito IS, Amado JMC. Tradução, adaptação e validação do questionário Fantastic Lifestyle Assessment em estudantes do ensino superior. Ciênc Saúde Coletiva. 2014;19(6):1901-9.

28. Ministério da Saúde (BR), Secretaria de Vigilância em Saúde, Secretaria de Atenção à Saúde. Política Nacional de Promoção da Saúde. Brasília: Ministério da Saúde; 2006. (Série B. Textos Básicos de Saúde).

29. Malta DC, Moraes Neto OL, Silva Junior JB. Apresentação do plano de ações estratégicas para o enfrentamento das doenças crônicas não transmissíveis no Brasil, 2011 a 2022. Epidemiol Serv Saúde. 2011;20(4):425-38.

30. Dias EN. Religiosidade e Fatores Associados: um estudo com residentes na cidade de Itajubá- Minas Gerais [dissertação]. São Paulo: Universidade de São Paulo; 2012.

31. Silva RP, Souza P, Nogueira DA, Moreira DS, Chaves ECL. Relação entre bem-estar espiritual, características sociodemográficas e consumo de álcool e outras drogas por estudantes. Rev Bras Psiquiatr. 2013;62(3):191-8.

32. Abdala GA, Rodrigues WG, Torres A, Rios MC, Brasil MS. A Religiosidade/Espiritualidade como Influência Positiva na Abstinência, Redução e/ou Abandono do Uso de Drogas. Rev Est Relig. 2010;1(1):77-98.

33. Ferreira GM, Staut TC, Araujo SP, Oliveira NC, Portes LA. estilo de vida entre brasileiros adventistas do sétimo dia. Lifestyle J. 2011;1(1):17-25.

34. Kanno DT, Sella LF, Oliveira NC. Estilo de vida de Adventistas do Sétimo Dia do município de Cotia, São Paulo. Rev Ciênc Méd (Campinas). 2014;23(3):137-44.

35. Meneses AFS, Santos EC. Sexo e religião: um estudo entre jovens evangélicos sobre o sexo antes do casamento. Clínica Cultura. 2013;2(1):82-94.

36. Kwok CS, Umar S, Myint PK, Mamas MA, Loke YK. Vegetarian diet, Seventh Day Adventists and risk of cardiovascular mortality: a sistematic review and meta-analysis. Int J Cardiol. 2014;176(3):680-6.

37. Fisher J. The Four Domains Model: connecting spirituality, health and well-being. Religions. 2011;2(1):17-28.

38. Ironson G, Stuetzle R, Ironson D, Balbin E, Kremer H, George A, et al. View of God as benevolent and forgiving or punishing and judgmental predicts HIV disease progression. J Behav Med. 2011;34(6):414-25.

39. Koenig HG. Religion, spirituality, and health: the research and clinical implications. International Scholarly Research Network. ISRN Psychiatr [periódico na Internet]. 2012 [accessed on 10 Feb 2015];1(2012):1-34. Available at: http://www.hindawi.com/journals/isrn/2012/278730/cta/

40. Murakami R, Campos CJG. Religião e Saúde Mental: desafio de integrar a religiosidade ao cuidado com o paciente. Rev Bras Enferm. 2012;65(2):361-7.

First author's address:
Marli Rosangela Cres
Centro Universitário Adventista (UNASP)
Estrada de Itapecerica, 5859
Bairro: Jardim IAE
CEP: 05858-001 - São Paulo - SP - Brasil
E-mail: marcres@uol.com.br

Mailing address:
Gina Andrade Abdala
Centro Universitário Adventista (UNASP)
Estrada de Itapecerica, 5859
Bairro: Jardim IAE
CEP: 05858-001 - São Paulo - SP - Brasil
E-mail: ginabdala@gmail.com