Recovery from a myocardial infarction or cardiac surgery is often accompanied by a host of psychological and physical problems (Bigos, 1981; Jenkins, Stanton, Savageau, Denlinger, & Klein, 1983; Magni et al., 1987; Stern, Pascale, & Ackerman, 1977). The consequences of a cardiac event include energy loss, recurring chest pain, dependence on others, and tension in social and sexual relationships. As patients begin to understand the ramifications of chronic heart disease and experience the emotions related to that understanding, enrollment in a structured, outpatient cardiac rehabilitation program can provide them with information, guidance, and support.

Despite the popularity of cardiac rehabilitation programs, their effectiveness remains controversial, and the mechanisms by which they achieve their outcomes have not been clearly delineated. In this chapter I present evidence suggesting that enhanced social support is a powerful but relatively untested component of all cardiac rehabilitation programs. The purpose of this discussion is to review the data related to these rehabilitation programs in the context of what is known about the effects of social support on the health outcomes, psychosocial adaptation, and
compliance of patients in the immediate period following hospitalization for cardiac disease.

The Need for Cardiac Rehabilitation Programs

The diagnosis of coronary heart disease has a profound impact on an individual's self-image and sense of well-being. This impact may be heightened when hospitalization is required. Whether the patient is recovering from an acute coronary event (myocardial infarction or out-of-hospital cardiac arrest) or from a surgical procedure (e.g., coronary artery bypass graft surgery, coronary valve replacement, or cardiac transplantation), recovery is often characterized by depression, anxiety, changes in self-image, and loss of self-esteem (Bigos, 1981; Cassem & Hackett, 1971; Waltz, 1986). Long-term emotional distress, family turmoil, and occupational problems occur in a significant number of patients (Finkelmeier, Kenwood, & Summers, 1984; Garrity & Klein, 1975; Stern et al., 1977; Jenkins et al., 1983).

The most difficult time period in the recovery process is the first month following discharge from the hospital (see Croog, Levine, & Lurie, 1968; Doehrman, 1977, for reviews of this research). Emotional distress, particularly depression, tends to peak after hospital discharge, rather than during hospitalization as one might expect. Several mechanisms can be posed to explain this trajectory. First, patients with cardiac disease frequently use denial as a defense mechanism to ward off anxiety. Most observers of acute-phase coronary patients find denial to be ubiquitous (Razin, 1982). The usefulness of this defense mechanism was documented by Hackett, Cassem, and Wishnie (1968), who found that patients who used denial in the coronary care unit were less anxious and experienced less morbidity and mortality on follow-up than patients who did not use denial. The return to the familiar surroundings of home, however, can seriously erode denial as a defense mechanism. Decisions about return to work, social commitments, and daily schedules must be made; the losses associated with a cardiac event—financial, social, and personal—can no longer be ignored once the patient returns home.

Family tensions also increase during the immediate posthospitalization phase, with oversolicitation on the part of family members being the most frequently cited source of conflict by patients (Jenkins et al., 1983; Wishnie, Hackett, & Cassem, 1971). Spouses have identified these early days as the most difficult and frightening time in the recovery process (Gillis, 1984). They feel responsible for the patient's welfare and are unsure