Despite the options of using analgesics and other modalities, pain continues to be moderate to severe in more than 50% of patients with cancer (Beuken-van Everdingen et al., 2007; Hammer et al., 2016). The multidimensional experience of pain involves many factors, including pain-related distress and perceived control over pain, which affect a patient’s functional status (Leung, Pachana, & McLaughlin, 2014; Vallerand, Templin, Hasenau, & Riley-Doucet, 2007; Wells & Sandlin, 2012).

Behavioral interventions to decrease cancer pain have focused on distress (Jacobsen, Møldrup, Christrup, Sjøgren, & Hansen, 2010; Wells & Sandlin, 2012). Although distress is important and should be assessed in all patients with cancer (National Comprehensive Cancer Network [NCCN], 2017), when general symptom distress and pain-related distress were compared in patients with cancer pain, distress from pain was found to be more upsetting than all other symptoms (Vallerand, Templin, et al., 2007). Assessing pain-related distress is essential in patients with cancer-related pain to develop interventions and effectively care for these patients. However, designing interventions to decrease distress is challenging because of the affective nature of the concept. The factors that lead to pain-related distress are more amenable to intervention strategies. Perceived control over pain, a factor that had not been previously considered, was found to have a direct effect on pain-related distress and mediated the effect of beliefs about pain and pain level on distress in ambulatory patients with cancer-related pain (Vallerand, Templin, et al., 2007).

African American patients with cancer have been shown to bear an excess burden of pain because of disparities in pain care (Anderson et al., 2015; Fisch