Unrelieved pain remains a significant problem for many patients with cancer despite numerous and varied treatment options. Studies have shown that unrelieved pain has negative consequences on patients’ and family caregivers’ mood, functional status, and quality of life. However, patients with cancer are reluctant to report pain and to take opioid analgesics (American Pain Society, 2003; Cleeland, 1998; Jacox et al., 1994a).

Patients’ personal beliefs and concerns about pain and its treatments and communicating with healthcare providers can negatively influence treatment adherence and pain management. When beliefs about pain interfere with managing pain, patients may have an attitudinal barrier to some aspect of pain management. Fears of addiction, feelings of stoicism, and desires to please providers have been associated with underuse of pain medication and inadequate pain relief (Jensen, Turner, Romano, & Karoly, 1991; Paice, Toy, & Shott, 1998; Riddell & Fitch, 1997; Turk & Rudy, 1992; Ward et al., 1993; Ward & Gatewood, 1994; Williams & Keefe, 1991; Williams & Thorn, 1989). In addition, Ward et al. found a positive correlation between high attitudinal barrier scores and high pain intensity scores.

In recent years, experts have developed clinical practice standards and guidelines for the treatment of pain in general and cancer pain in particular (American Pain Society, 2003, 2006; Department of Veterans Affairs, 2001; Jacox et al., 1994a; National Comprehensive Cancer Network, 2007; World Health Organization, 1996). Although these treatment guidelines provide valuable information for healthcare professionals, unrelieved cancer pain remains a significant problem for many patients with cancer despite numerous and varied treatment options.