Although cancer is curable in many, if not most cases, it continues to be feared. Research is producing insights and advances into the causes and cures for cancer, but the problem of symptom management continues. Symptoms from the disease and its treatment with resulting distress continue to be challenging and, according to the National Institutes of Health (NIH) State-of-the Science Panel, should be the focus of future research (Patrick et al., 2003).

Pain is a symptom that has been identified to be among the most prevalent for patients with cancer (Gordon et al., 2005; Modonesi et al., 2005; Stromgren et al., 2006; Vallerand, 1997; Walsh & Ribicki, 2006). Pain is a subjective and multidimensional experience that requires patients’ self-report for healthcare providers to fully understand it (Shin, Kim, Kim, Chee, & Im, 2007; Vallerand). Because of its multidimensional nature, symptom assessment should include intensity, timing, and quality as well as distress and interference with daily functioning (Armstrong, Cohen, & Eriksen, 2004; Lenz, Pugh, Milligan, Gift, & Suppe, 1997).

Rhodes, McDaniel, and Matthews (1998) conceptualized the symptom experience to include patients’ perceptions of and responses to symptom occurrence and symptom distress. Symptom occurrence, according to this conceptualization, includes temporal features and severity (intensity) of the symptom experience to include patients’ perceptions of and responses to symptom occurrence and symptom distress. Symptom occurrence, according to this conceptualization, includes temporal features and severity (intensity) of the symptom experience to include patients’ perceptions of and responses to symptom occurrence and symptom distress. Symptom occurrence, according to this conceptualization, includes temporal features and severity (intensity) of the symptom experience to include patients’ perceptions of and responses to symptom occurrence and symptom distress.