You are encouraged to read the whole book, and please make a proper citation if needed.

May, R. (1967). *Psychology and the human dilemma*. D. Van Nostrand Company.

1. The first is a new way of seeing the reality of the patient called phenomenology… The phenomenologists hold that we must cut through the tendency in the West to believe we understand things if we only know their causes, and to find out and describe instead what the thing is as a phenomenon – the experience, as it is given to us, in its "giveness." (88)
2. The second emphasis in the existential psychotherapeutic approach is the principle that all ways of understanding men, all methods of psychotherapy, are based on some presuppositions, and each approach needs continually to examine these presuppositions. (89)
3. The critical battles between approaches to psychology and psychoanalysis in our culture in the next decades, I propose, will be on the battleground of the image of man – that is to say, on the conceptions of man which underlie the empirical research. (90)
4. The third emphasis of the existential psychotherapeutic approach stems directly from the first two and goes by the thorny terms "ontology."
5. We have two persons in a given space, in a given world. By "world" here I mean, as in the classical sense of the word, a structure of meaningful relationships. These two people, patient and therapist, have different motives for being here. We do not know the motives of the patient; he got here, however, and therefore some meaningful act is involved. (94)
6. My patient sits there in the chair. I know practically nothing about him. But I can assume that he, like all living organisms, seeks to preserve some center, and I assume he is here is the chair in my office in the process of doing that. The first ontological characteristics, thus, is that all human beings are potentially centered in themselves, no matter how much that centeredness is distorted in conflict. I assume in the same breath that this man (like all organisms) has the character of self-affirmation, that is, the need to preserve his centeredness. (94)

7. Another thing to be noticed about this patient who has come to my office is that immediately there is a relationship. Even in anticipation when I or the patient thinks of the meeting, there is a relationship. (95)
8. From the ontological approach, we see that sickness is precisely the method that the individual uses to preserve his being. We cannot assume in the usual oversimplified way that the patient automatically wants to get well; we must assume, rather, that he cannot permit himself to give up his neurosis, to get well, until other conditions in his existence and his relation to his world are changed. Neurosis is an adjustment activity which has within it the creative potential of the individual that must in one way or another be shifted to the constructive goals in his process of overcoming his problems.
9. The next thing we observe about this patient who now sits in front of the therapist, is that he is participating with the therapist on characteristic. But the principle of awareness itself is not enough. So we arrive at the distinctive form of awareness in human beings, namely self-consciousness. The word, "awareness," comes from the root Anglo-Saxon term, *gewaer*, which in turn comes from *waer*, which refers in his whole family of terms to knowledge of external threats – that is, knowledge of danger, of enemies, knowledge requiring defensive strategies. The cognates of this word, "aware" are the terms "wary" and "beware." (96)
10. Consciousness, on the other hand, from the Latin verb *conscire*, refers to knowledge which is felt inwardly, that is, to knowing with, not only with others but with oneself in the sense of consciousness of the fact that I am the being who has a world.
11. I propose that unconscious experience can be understood only on the basis of our concept of consciousness. We must posit that the patient comes as a potential unity, no matter how clearly we can see that various neurotic symptoms have been blocked off and thereby have a compulsive effect upon him. The neurotic's very symptoms, disruptive and disjunctive as they appear to us on the outside, are expressions of his endeavor to preserve his unity. To preserve this unity he has to block off, refuse to actualize, some potentialities for knowledge and action. (97)
12. Now "unconsciousness" consists of the experiences that the person cannot permit himself to actualize. The questions in understanding unconscious phenomena are, "How does this individual reject or accept his possibilities for being conscious of

himself and his world?" "How is it possible that he should shut out something which on another level he knows, and even knows that he knows?"

13. Our goals with respect to anxiety and guilt should be not to wipe them out (as though we could even if we wanted to!) but to help people, our patients and ourselves, to confront anxiety and guilt constructively. (105)
14. Encounter is what really happens; it is something much more than a relationship. In this encounter I have to be able, to some extent, to experience what the patient is experiencing. My job as a therapist is to be open to his world. He brings his world with him and therein we live for fifty minutes. Learning to do so may be highly taxing; to experience somebody else's anxiety can be extremely painful. It is painful enough to experience one's own, when one has no choice but to bear one's own world. (108)
15. Our chief concern in therapy is with the potentiality of the human being. The goal of therapy is to help the patient actualize his potentalities. The patient after therapy may well bear more anxiety than he had before, but it will be conscious anxiety and he will be able to use it constructively. Nor is the goal the absence of guilt feeling, but rather the transformation of neurotic guilt into normal guilt, together with the development of the capacity to use this normal guilt creatively. (109)