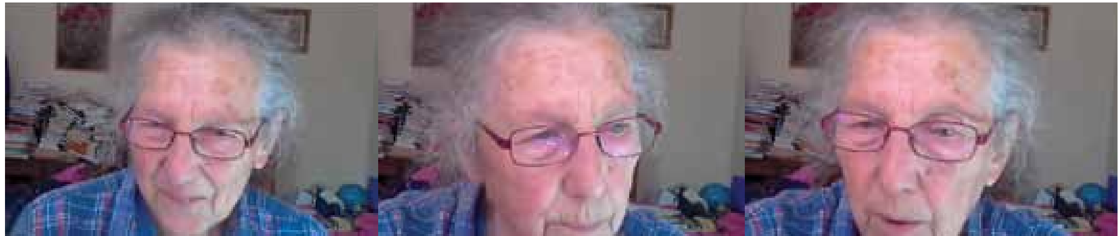
Presenting Leading Art Therapists: Marian Liebmann, Ph.D., ATR, OBE

Marian Liebmann qualified as an art therapist in 1979, and worked in art therapy with offenders, with women's groups and community groups, and for 19 years in the Inner City Mental Health Team in Bristol, UK, where she developed work on anger, also with asylum seekers and refugees. She has lectured on art therapy at universities in the UK, Ireland, Eastern Europe and Baltic countries. She also works in restorative justice, mediation and conflict resolution, and has run Art, Conflict and Anger workshops in many countries. She has written/edited twelve books, including Art Therapy and Anger and most recently Art Therapy with Physical Conditions and Art Therapy with Neurological Conditions. In 2010, she was awarded her PhD from Bristol University. In 2013, she was awarded OBE for her contributions to art therapy and mediation.

Q: Could you tell us about your personal path and how did it leaad you to art therapy?

A: It's probably not a conventional path. My parents were both scientists, so I followed suit. I always loved art, but it was always strictly a hobby. As an immigrant child, you always have to think about how to earn a living — there's no family to lean on. My parents especially, who were Jewish refugees from Nazi Germany, whose families were all killed.

I completed a science degree in physics and mathematics, just like my parents, and then I went into teaching because I was getting more interested in people. I was teaching maths in junior high. The reason I chose science was because I could continue persuing art on my own, whereas science was more demanding and required learning. I didn't like having to choose, but that was the system at the time. After completing three subjects— math, chemistry, and physics — I had to



choose which one to continue studying at the university. As it was, I didn't have any career guidance to tell me, "Look, you're good at everything, why don't you study anthropology or sociology?" By the time I got to university to study physics, I didn't enjoy it at all. But because I'm the sort of person who finishes what I start, I went on and completed my studies.

That skill really played a significant role in my life. It's those little things that make all the difference. I think that my ability to finish things combined with hard work, is the reason I've been able to write so many books—not because I'm especially clever or an especially good art therapist, but because I can finish what I start.

Q: Has your background in physics influenced your art therapy practice?

A: In two ways. First, I learned to be very methodical — especially in stucturing art groups. Second, I became scientifically suspicious of things that appear scientific, especially statistics and graphs. The ways measures are taken and conclusions are drawn in research often demand spotting inconsistencies. That's been useful, especially today when people are looking at statistics of effectiveness.

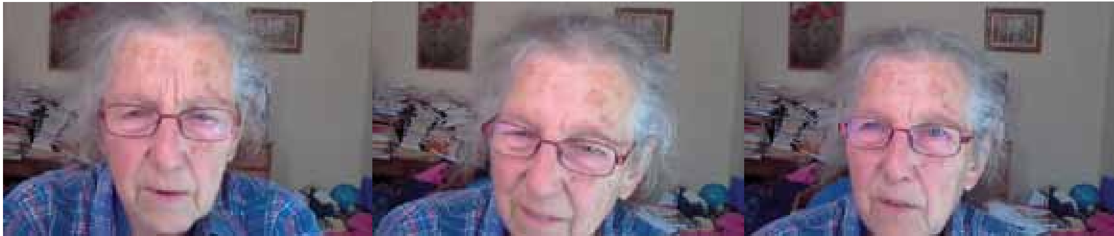
Some research methods are not suitable for certain topics. Something that is taken as a gold standard- the randomized control trial — needs to be examined for its actual usefulness. It's interesting to see that case study methods are gaining respect because they are often more suitable for addressing the task at hand.

Q: Would you say that art therapy will be recognized only through randomized trials, or has there been a turning point in science that allows art to enter the scientific domain through case studiesor another research design?

A: It's hard to say. I'm not a researcher; I'm more of a practitioner. But I am skeptical about some research methods.

I was asked recently to be an external examiner for a PhD art therapy student, partly because it involved work in prisons. Much of my work was focused on prisons or prisoners. It was interesting because most of the research was case study-based, and it was very gripping to read about the transformations some people went through.

A classic outcome study was also done, which showed some movement in certa-



in aspects of mental health—but you don't get statistically significant differences. For example, in criminal justice, if you get a 14% reduction in reoffending, that's good. To make art therapy research statistically respectable, one would need a huge sample, and there are many difficulties in conducting such research.

There was a lovely study done with 400 people in London — art therapy with people with schizophrenia — where a significant effect was shown. Then they replicated it in a rural area, and they didn't get much of an effect. There were many differences in the setup — for example, a lot of groups in rural areas were poorly attended. Why? They had a poor bus service. Simple things like that can completely derail the process. Another problem they had was recruiting people in rural areas within the narrow criteria that the research specified.

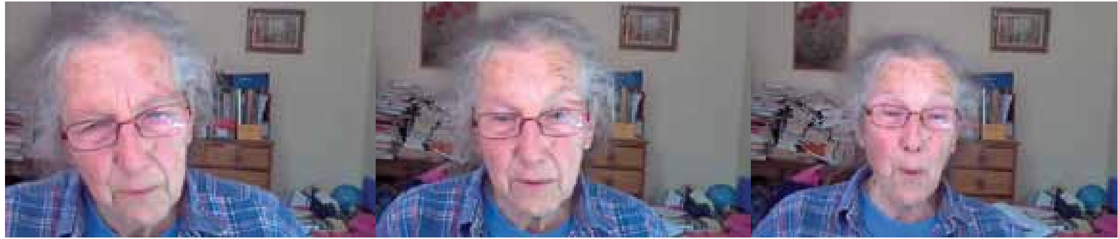
When I was practicing art therapy, a psychiatrist once asked me, "How do you know it works?" Just to appease him, I created a five-point scale questionnaire asking about patients' problems, with a graded scale from 'very bad' to 'not much of a problem' experience. So there was a humanity to it — the patients decided what their problems were. After six months of art therapy, I gave them that same scale to fill in, and usually I could see the positive shift – and they could too, which they found encouraging. However, it had no research viability as it was too personal.

The art therapy department also tried to give out a questionnaire for clients to complete together with their art therapist. But because it wasn't independent — the therapist they worked with was filling it out — it wasn't seen as valid. So someone external was asked to administer the test, but since the clients had no relationship with that person, they didn't want to cooperate with the test.

Research is a very complex process, and I take my hat off to anyone doing research. However, you do need much more than a bunch of numbers when researching anything related to people.

Q: How did your transition from science to art therapy actually happen?

A: I just loved art — it was a release from the scientific approach. I was teaching in junior high, which I also didn't enjoy very much, since I wasn't good at mob control — the children were misbehaving, talking,



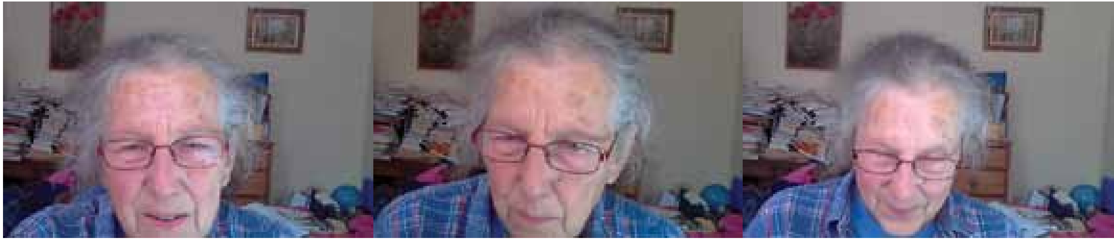
and restless. And I spent my spare time going to art classes and painting at home. I joined an art club. In one of the newsletters, I saw an article about art therapy. I was immediately interested! So when I moved to a job in London, I went to visit a couple of art therapists working in big hospitals, but hardly anyone had ever heard of it. So I thought, that's interesting — I want to do that. People would say, "You have a science degree, you can't study that." But I worked my way sideways. I attended a number of art therapy workshops, and when my work was transferred to Bristol, I continued attending them.

Soon I got a job at a Day Centre for ex-offenders, being responsible for education, art, and crafts. We did lots of group work. Everything I know about social work I learned there — from my colleagues and the participants. I ran sessions that were actually art therapy, but we didn't call it that. We called it art workshops, but we were working on personal issues and developing a group approach.

After that, I completed an MA in Art Therapy at Birmingham. My dissertation was on art therapy groups, where I collected ideas from art therapists in Bristol, Birmingham and London. I produced a booklet and sent it to all those who contributed, as a way of thanking them for their help. Many other art therapists also wanted a copy, and I found myself sending out parcels of books all over the world. I decided it was time to find a publisher and wrote extra chapters on how to use the ideas in the book. It was published in 1986 as 'Art Therapy for Groups'; the second edition was published in 2004.

After my course there were no art therapy jobs nearby — only miles away. I had a baby by then, so long travels to work were impossble and I had to try something else. I heard of a job with victims of crime — they had so many issues, and nobody was paying them any attention.

Nowadays, this area is well established, but when I was doing it, we had a team of volunteers. We visited people and worked every single day of the year, including Christmas Day. We just turned up at people's doorsteps and offered help. They were extremely grateful. The people had different issues and needed support, and we did our best through volunteering and my half-salary leadership position. Today, it is a statutory service - the police are supposed to leave a phone number so you can call if you need help.



I also ran a lot of different art groups at that time — art workshops, peace groups, church groups, and a voluntary organization for parents who were struggling.

I decided to take another qualification, in social work, with a specialization in probation. Now probation works more toward corrections; it's no longer social work. But back then there was a lot of freedom within the probation service. Some professionals did mountain climbing, some taught motor mechanics, and I was the 'art therapy probation officer'. I did quite a bit of art therapy there, which resulted in two books: Art Therapy in Practice (1990) and *Art Therapy with Offenders* (1994).

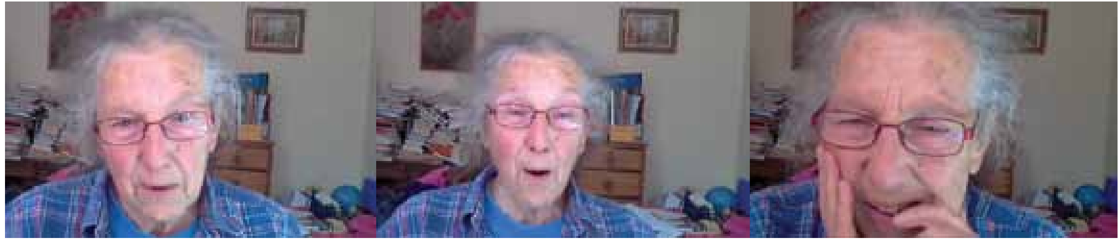
Q: Was there something specific you were looking for or found in the course of working with groups at that time?

A: I developed this technique of comic strips, which was incredibly useful. Working with these macho men and boys, I knew they wouldn't respond to an invitation to art therapy — but if they were offered comic strips, they understood what that was. I learned tremendous amounts from this technique. Everything turned out slightly different in the comic than in how they talked about what happened.

The most dramatic one was the very first case I did, with a sex offender. He told the story one way: "It was a rainy day, and my car didn't start, so I had to take the bus not to be late for work". I imagined a crowded bus and some kind of incident that might have gone too far. But when I got him to draw out what happened, he showed missing the bus, and then the next bus coming — with only one person on it, a young woman. When he got on, he sat right next to her and put his hand up her skirt.

When asked when knew he was going to commit an offence, he pointed to the picture of himself getting on the bus. Suddenly, we were dealing with something much more deliberate. The narrative had changed.

Another interesting detail was that this person drew childlike faces facing forward — so it wasn't about relationships. I also learned that every time this man had a row with his wife, he would go out and commit a sexual offence against another woman. Unlike other times, when I would teach people how not to have rows with



their wives, I taught him how to have them — so he wouldn't take it out on others.

Towards the end of working with Victim Support, I discovered restorative justice. Somebody handed me a scruffy little piece of paper and said, "I think this is for you"—a course in mediation skills in London. When I learned those skills, everything really fell into place.

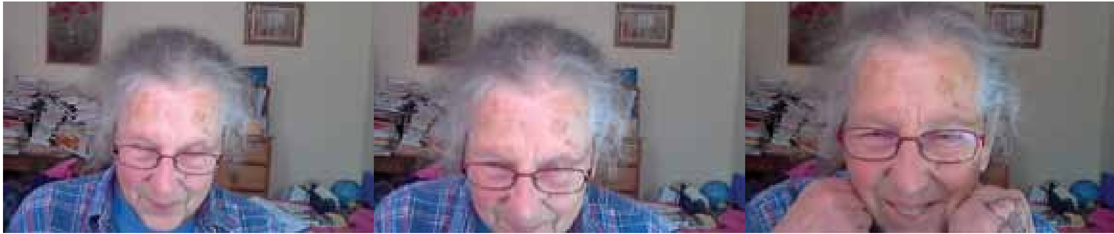
As a probation officer, I began bringing victims and offenders together, if they were willing. I also helped establish a community mediation service — for example, between neighbours who were fighting. The Labour government later introduced Youth Offending Teams that incorporated restorative justice. These were quite successful: the youth offending teams would talk to young people about what they had done, how it affected others, and sometimes contact the victims to ask if they wanted something from the offender—perhaps a meeting or a letter of apology. A lot of valuable work happens at that stage of a process.

In other services around the country, ones I am connected with locally, we get refferals from police and self-referrals. There were many important cases. I helped start the Bristol Mediation scheme, and initially led the training courses because I was the only one who had completed the training. This scheme is still running after 35 years. Later, I was invited to be Director of *Mediation UK*. I had to take a leave of absence from probation and served as director for four years. It might sound glamorous, but it was really just me and a part-time secretary. Hardly anyone had heard of mediation—I would get calls for "Meditation UK" or "Medication UK."

So my job was to explain to anyone and everyone what mediation actually was. When *The Independent* newspaper published an interview about mediation, interest suddenly escalated from around 10 local mediation services to about 110 within the same year. Sadly, many of those centers were later closed due to austerity measures.

Q: Would you say that now is the perfect time to apply these mediation techniques more broadly? You mentioned neighbors — where it all begins — but what about larger groups?

A: Everything is so polarized at the moment. In recent years, I've been leading dialogue groups with people of opposing opinions, always with another facilitator.



For example, one group was pro-Palestinian, the other pro-Israeli; another included different road users with their very different perspectives.

There's such a strong polarization now that people feel they can't even talk to someone with a different opinion. In the UK at the moment, things are so divided you wonder where the middle ground is — where there's room for mediation skills. The protests happening everywhere — taking one side or the other — isn't the way. You can't make progress by shouting at each other.

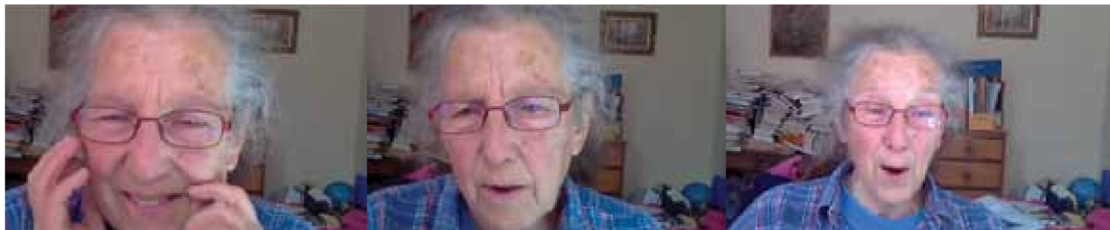
The Art & Conflict groups that grew out of my work with Mediation UK were based exactly on this: instead of depicting conflict, how about turning the telescope the other way around — using it to resolve conflict? I developed workshops around this idea. At the London Art Therapy Centre, I designed weekend workshops: Anger on Saturday, Conflict on Sunday. I am still running these.

In one exercise, people draw in pairs without instructions. They naturally arrange themselves in different configurations around the paper — two people side by side, two across the corner, two opposite each other — and we observe what happens. They're literally seeing things from different points of view. You get a lot of surprises — and realize how many conflicts start simply because of differing perspectives. We also have a lot of fun. I don't think making things painful is ever a good way forward.

When my daughter was a teenager, I started working as an art therapist in the Inner City Mental Health Team (Community Mental Health Team, or CMHT). I really enjoyed that work. The team was set up to meet the needs of people who were not getting a mental health service or did not sign up for it — homeless individuals, members of African-Caribbean and Asian communities.

The team had a very diverse staff. I was born in Britain but, as the child of immigrants, I always felt only "a bit British." Here, I was among others like me — from France, Germany, Italy, Greece, or British born to immigrant parents — it was fascinating.

For example, there was an Asian woman who had difficulty engaging in art therapy, and I noticed she had a problem with her hand. I learnt from an Asian colleague that Asian cultures often stigmatize physical disabilities, especially in women.



There was also some prejudice against me as a white therapist— Asian clients were not referred to me, assuming they wouldn't want art therapy. But it seemed wrong that those people weren't even being offered the service.

We discussed these issues as a team and things eventually changed. But you have to keep explaining, especially in a mental health system that's so medication-oriented.

Another problem with referrals was that many clients got referred to me simply because they like painting, and colleagues thought that meant they should have art therapy. But that wasn't really what I could offer. I realized that they had a real need – not for art therapy but for a space to create art and be supported, because they couldn't afford regular classes or manage in mainstream settings.

When I was writing my art therapy dissertation, one of the places I visited was Studio Upstairs. To meet the need for supported art space, I encouraged the founder to bring the idea to Bristol, and together with another art and occupational therapist, we worked for several years to make it happen — and in the end, it did! I never worked there myself, as I was busy with other projects, but it's still going strong. The art and the people, it works! I was there just a week ago for their exhibition opening.

Q: Is it open to the public?

A: A person must either be referred or pay privately. Social services cover part of the cost. They usually refer people for six months, expecting that to be enough for recovery. But some have been coming for years, and I'm sure it keeps them out of hospital.

Q: Is there an official art therapy program in hospitals in the UK?

A: Yes, for instance, one psychiatric hospital had a 'Green Hut' which was an open studio. But authorities now view treatment in such narrow terms that programs like that no longer receive funding. Mental health services typically offer 12 sessions of personal therapy or 6 of group therapy — there is a limit to treatment. And art therapists now mostly work in rooms that need to be shared with other professionals.

When I started working in the Mental Health Team, I had a client for nine years.

She made great progress, but then the service became narrower and narrower. I often had clients for two years or more. The challenge is that if you keep clients that long, you can't take new ones, so rationing becomes necessary.

Within a year, clients usually discover how serious they are about working on themselves. Some just need someone to hold their hand; others truly engage in therapy. After a year, you can decide whether continuation makes sense. That's how I worked, but I think it's much more limited now.

Q: Does art therapy have a place in public health?

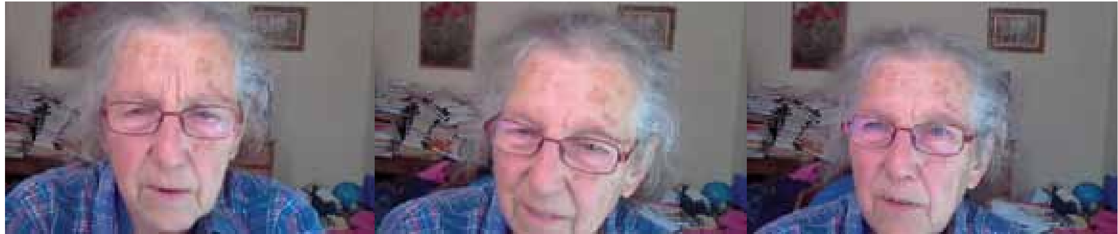
A: There are paid art therapy services within public health, but also many voluntary projects — like *Mind*, which sometimes runs art therapy groups. Recently, our *Art Table* team (in the refugee charity *Borderlands*) connected with an art therapist working with a mental health team for PTSD. It's a short-term, six-week program — individual or group — and then I hope the *Art Table* can offer continuity and a space to keep creating.

Most "*art as therapy*" or "*art for wellbeing*" is no longer provided through the national health system — it's client-oriented and often volunteer-based. But some qualified art therapists work within those voluntary organizations.

Q: Are "art as therapy" groups often led by artists?

A: Yes, there's a growing movement of "social prescribing artists" who aren't trained as art therapists but are actually quite experienced at working with people with mental health problems. The colleagues I work with at the *Art Table* and I wrote a manual called "*How to Set Up an Art Table*" (https://www.culturehealthandwellbeing.org.uk/sites/default/files/2024-04/Borderlands-Art-Table-Manual-final.pdf, 2020), where we discuss distinctions between art therapy, art as therapy, and art for wellbeing.

It's not always clear-cut. For example, a man from Somalia with learning disabilities and hearing impairment once painted something festive and said, "This is for Christmas." Another time, he painted what looked like boxes and said, "These graves — my family." You realize you're crossing into therapy. You have to have the skills to handle that, because anything can surface at any time.



There are so many changes in art therapy today. In the beginning, most people connected it to psychoanalytic theories. Now there are links with neuroscience, and many different ways of working.

Q: Why is art therapy more present in mental health than in physical health settings?

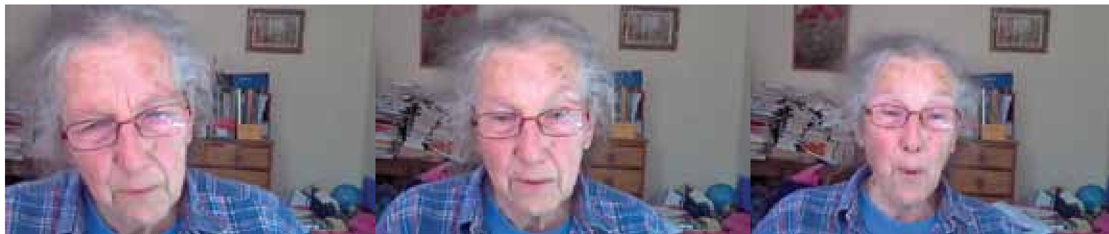
A: A variety of reasons. Many physical health treatments are short-term. Also, if a treatment works, people don't look fur-ther — that's how physical medicine works. But in mental health, where treatments are long-term and often insufficient, people are more open to new approaches. Of course, there's always a mental health component to physical illness, especially with chronic conditions. And modern art therapy started in TB clinica during or just after World War 2.

Q: You edited a book with Sally Weston on art therapy and physical conditions. Could you tell us more about it?

A: I thought I'd written enough books — ten or twelve by then — but people kept coming to me for help publishing theirs. That's how the book *Art Therapy with Physical Conditions* (2015) came about. It includes many examples of art therapy with different physical conditions, including cancer patients, partly influenced by the Bristol Cancer Help Centre, which pioneered alternative treatments. I worked there for five years in short, residential group courses. Each 45-minute session had to introduce art therapy, allow time to create, and then close with sharing. People rotated through different therapies, so people used to come in from their healing session and wanted to paint what they brought from there, or they would go from the art therapy session to healing or psychotherapy with the picture they'd made. So it was quite interesting how it interplayed.

The book also includes chapters on ME (myalgic encephalomyelitis), colitis, health of homeless persons, people with learning disabilities, and terminal illness — showing the overlap between physical and mental health. Because we had too many chapters, we divided them: one volume on physical health and another, on neurological issues — covering brain injury, epilepsy, dementia, and more.

One remarkable chapter was by an art therapist who had a brain injury himself, describing his recovery and how he



managed to come back to work. He was also an expert in using mobile phones in art therapy with teenagers. Another moving chapter was about coping with bipolar disorder and rheumatoid arthritis It's amazing to hear the story from the point of view of the art therapist, because we are not immune to these conditions, so we have the opportunity to see it from the other side of the mirror.

Q: Art therapy is done with physical conditions, especially long-term conditions, be it physical or neurological. In which way is art therapy practiced inside the health institutions in UK?

A: It depends entirely on where you are — both in the system and geographically. In major psychiatric hospitals, several art therapists work with mental health patients or elderly populations. Smaller units — like those for eating disorders — often have outpatient programs with one or two part-time art therapists.

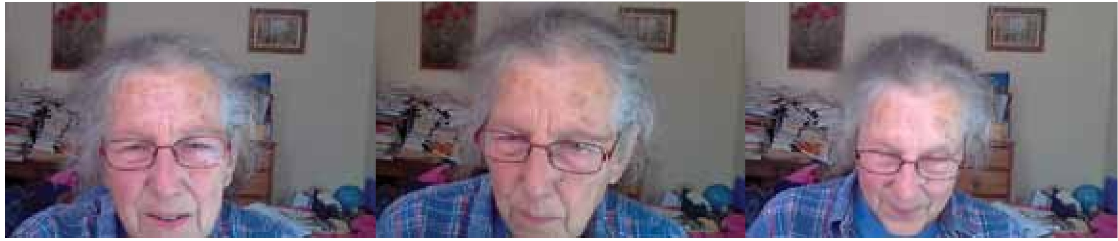
The oncology departments in hospitals often have art therapists, too. Around Bristol (the largest city in south-west England), there are many art therapists because of the local art therapy training program in Newport, South Wales (40 minutes drive away) — 10 to 20 new graduates each year, all looking for work. Many end up in schools, where there's now an obligation to provide social and mental health support.

Working in the NHS is considered the pinnacle — it's stable and properly paid — but there are far more qualified art therapists than positions. So many art therapists have to invent their own jobs.

There are also art therapy groups in new programs, such as *The Hope Service* for refugees. One art therapist started there as a mental health worker and gradually negotiated one, then two, then three, and now four days a week of art therapy. That's often how new posts emerge.

Q: It's interesting that art therapy has had more success in education than in mental or physical health.

A: Yes. The good thing is that if there's a specialists' psychological team, art therapists will now be included. They used to be part of occupational therapy teams — which wasn't ideal, as art therapy was seen as a pastime rather than a treatment. Now, art therapists work alongside psychologists, though still not as well paid. How many art therapists you



find depends on whether the leadership believes in its value. Sometimes art therapists get in "through the back door", by doing other jobs not labelled as art therapy, such as 'mental health worker'.

The medical system is constantly changing, and years of underfunding make it difficult to advocate for art therapists when basic services are struggling.

But when management sees what art therapists can do — when they see the effect of the work — they can't deny it. There's nothing like presenting a team with client images while presenting the cases. The picture speaks by itself. It is a strong message.

Q: You've written so many books — would you tell us a bit about them?

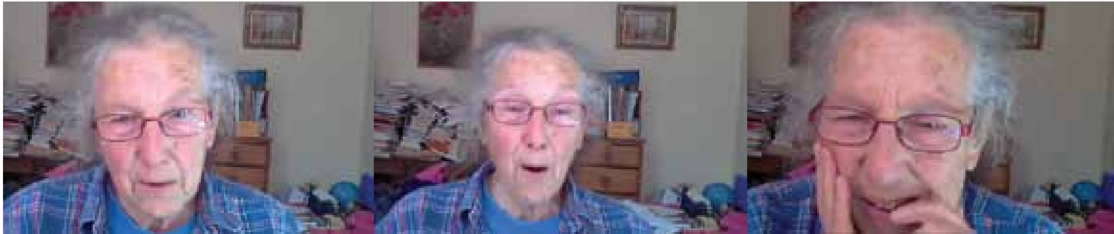
A: My first book (already mentioned) was based on my dissertation. I first produced a home-printed version, but after so many people asked for copies, I decided to publish it. Then more and more professionals — social workers, doctors, therapists — wanted us to explain art therapy to other professions, so *Art Therapy in Practice* (1989) was born.

Art Therapy with Offenders (1994) came about because my art therapy work in probation wasn't recognized. Other professionals working with offenders had the same experience, so I suggested we all contribute chapters — and that became the book. For twenty years, there was no other publication on the subject.

Offenders in mental health secure units don't respond well to medication, so art therapists, drama therapists, and music therapists often work alongside psychologists. I'm proud that our work changed perceptions.

Then came *Arts Approaches to Conflict* (1996) and *Art Therapy and Anger* (2008). I couldn't say the work on conflict and anger in probation was enjoyable, but I always came home feeling I'd achieved something.

CBT (Cognitive Behaviour Therapy) philosophy was dominant because it had the strongest research evidence. People could understand their anger and take preventative steps. When I later joined the *Inner City Mental Health Team*, a psychiatrist came in complaining that he had all these angry clients and asked, „Does anyone here work with anger?" Suddenly, all my colleagues buried their heads in their admin work, suddenly finding it very interesting, and I heard



a little voice (mine) saying: „I do”, and suddenly, I had 17 clients!

I started an anger group using CBT techniques, meditation, and powerful exercises from a manual for young people with anger, putting it in some kind of sequence. At first, some women dropped out. One told me, “Well, I didn't really have a place there, the men talked all the time.” I persuaded her to come back and explained it to the group and the men were all quite offended. We restructured the sessions, dividing discussion time equally, and it worked better.

After that, I decided to run a women-only group. In the third session, they all shared that they had been sexually abused. So I asked, „Would you come to this group if it was mixed?“ „No way“ they all said.

I became curious about anger and wanted to write a book about it. As preparation, I wanted to read all the books on anger, I started searching on the internet, and then when I got to the 100th book title – I stopped. There was no way I could read 100 books. I would much rather talk to people than read, so I talked to 20 or more psychologists, teachers and art therapists. But when I looked at all my notes, I couldn't make sense of them, because, some people said that the best way was bashing cushions, while others said never to do that cushion bashing stuff. So I looked at the chapters and what contributors had written and I developed a grounded theory approach drawing out the categories from the chapters.

I like working at the edge of things — where there’s no established body of knowledge. When publishing the book on physical health, a reviewer told me that anecdotal material was no longer acceptable and that I should replace new writers with established ones and start with theory and literature reviews. But that doesn’t work if there isn’t existing literature to review, and theories that really apply. Also I wanted to include new writers, as they were doing the pioneering work.

Too often, art therapy borrows other aproaches and theories — Jung, Freud, Object Relations; I think the real theory of art therapy is yet to be written.

Transfer: Thank you so much for your time, knowledge, experience, and kindness — and for everything you do. May you continue to find many new edges to work on!