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Bridging Western Music Therapy and the *Ndëpp* Ritual from Senegal:

Opportunities and Challenges

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Abstract

This essay explores links and tensions between Western music therapy and the Senegalese *Ndëpp* healing ritual, asking how bridges can be built across cultural frameworks. Reflections draw on the author's fieldwork in Senegal and Europe, supported by an interdisciplinary review of music therapy, psychiatry, sociology, and ethnology literature. Parallels emerge in the use of rhythm, song, and ritual, yet fundamental differences remain: Western music therapy predominantly focuses on the individual, while *Ndëpp* is rooted in community and spirituality. These contrasts expose the limits of Western categories when applied cross-culturally. The author recommends music therapists to adopt culturally sensitive approaches, engage with local traditions, and critically reflect on their own positionality. Interdisciplinary dialogue can foster more authentic, equitable, and inclusive therapeutic practices.

Keywords: music therapy; Ndëpp ritual; cross-cultural healing; cultural sensitivity; Senegal

Introduction: Conceptualizing the Bridge Between Music Therapy and Ndëpp

I would like to open this essay with several fundamental considerations that I regard as essential. These reflections provide the conceptual framework within which the present text has been developed, while also delineating the limitations arising from my positionality as a white, European woman. Such critical self-reflection ought to have occurred much earlier—retrospectively, during the preparatory phase of my music therapy practice project in 2008. Had this process taken place at that time, the outcomes might

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have been more culturally attuned and methodologically robust. Accordingly, the purpose of this essay is to revisit, analyse, and, where possible, critically acknowledge and validate the omissions of that earlier phase, situating them within the present context.

As a white, female author trained in Western music therapy, my reflections are inevitably shaped by the privileges and limitations of my background. When traveling to Dakar for my practical music therapy project in 2008, I was perceived as a *Toubab*—an outsider whose presence carried both curiosity and implicit authority. This position granted me access to spaces and recognition within academic frameworks, while at the same time creating distance from the cultural and spiritual depth of the *Ndëpp* ritual. My perspective therefore cannot claim neutrality; it is informed by the values and definitions I absorbed in European institutions, and by my own lived experience as a young Western woman entering a Senegalese healing context.

Recognising this positionality is part of an ethical stance in cross-cultural therapeutic work. It requires acknowledging that my interpretations are partial, that I am writing from a position developed from my personal experiences, and that my presence risks reproducing historical patterns of imbalance between Western frameworks and African traditions. By naming these dynamics, I aim not to erase them but to remain transparent about the vantage point from which I write and actively seek to listen to and amplify voices from Senegalese communities and other non-Western colleagues.

Music Therapy Project

In 2008, I journeyed to Dakar, Senegal's capital, to undertake the final clinical project of my music therapy studies at *ArtEZ Hogeschool voor de Kunsten* in Enschede, The Netherlands, Europe. My goal was to facilitate music therapy group sessions with female sex workers, assessing the possible positive impacts on their psychological health and symptoms of post-traumatic stress disorder (PTSD). I was supported by staff from *ENDA Santé*, a Senegalese NGO dedicated to combating HIV and malaria and enhancing community health since 1988 (*ENDA Santé*, 2024). Following this project, I conducted similar sessions in collaboration with the knowledge and expertise centre for sex work and human trafficking SHOP in The Hague, The Netherlands, allowing for cross-cultural connections and comparisons.[1] After several weeks of practical work and additional months of writing, I completed my bachelor's degree in music therapy in 2009.

As a young, white, Luxembourgish female music therapy student in Dakar, I was deeply moved by the musicality, creativity, and openness of the women I worked with. At the same time, my role as a European student shaped how these encounters unfolded. Introducing *djembé* playing, for example, I initially explained how to hold and strike the instrument—only to discover that the women immediately filled the rhythms with their own vitality, joy, and pain. This contrast revealed both the privilege and the limitation of my position: I brought instruments and a therapeutic framework, yet I depended on the women's energy and cultural knowledge. My attempts to evaluate outcomes with Western tools, such as "Smiley scores," (i.e., Self-Assessment Manikins, a self-Assessment instrument developed by Bradley & Lang in 1994) also quickly showed their inadequacy in a context where emotional expression followed different cultural norms. When some women compared our sessions to the *Ndëpp* ritual, I realized that my work resonated with existing practices in ways I had not yet been able to articulate, but which have guided my reflections ever since.

[1] More about SHOP can be found at: https://www.shop-denhaag.nl/

Transitional Reflections

These experiences prompted deeper reflection on how Western music therapy concepts intersect with Senegalese healing traditions, particularly the *Ndëpp* ritual. To contextualize this reflection, I turned to interdisciplinary perspectives that illuminate how healing, music, and culture intertwine.

Project Details

My final project in 2008 was practice-based and centred on active music therapy group sessions involving drumming, singing, and dancing. The sessions were conducted with female sex workers in two different contexts. First, in Summer 2008, during the rainy season, in the suburbs of Dakar, Senegal, I conducted sessions in collaboration with the NGO *Enda Santé*. Second, I conducted sessions in The Hague, the Netherlands, at SHOP (i.e., a foundation supporting sex workers) during the autumn and winter of 2008.

Evaluation of the project's impact entailed a combination of several approaches: (a) direct observation of the group sessions, participant self-evaluations using a Smiley-scale[2] (Bradley & Lang, 1994), and (b) interviews and questionnaires with social workers involved in the project. The practical work was further informed by a review of literature on post-traumatic stress disorder (PTSD), prostitution, and music therapy. The choice of locations was shaped both by practical access and institutional collaboration in addition to the opportunity to compare West African and European contexts. Senegal, where prostitution is legalized and regulated, offered a structured framework and the support of an established NGO. The Netherlands provided a contrasting European setting in which sex work is also legalized but embedded in very different social realities. These placements enabled a cross-cultural comparison while building on the researcher's professional opportunities.

Evaluation of the clinical project highlighted four key outcomes:

1. *Music therapy as a positive intervention*: group drumming, singing, and dancing generated joy, distraction, and relief from daily struggles. Participants reported improved emotional well-being, solidarity, and moments of empowerment. Music also offered a non-verbal means of expressing trauma-related emotions, thereby reducing isolation and shame.
2. *Challenges*: In Senegal, practical barriers included the rainy season, lack of transport funds, and limited familiarity with emotional self-reporting. Financial expectations sometimes influenced participation. In The Hague, many women were in acute crisis (e.g., escaping pimps or trafficking networks), which led to irregular attendance.
3. *Cultural and contextual differences*: Senegalese participants, mostly mothers still active in prostitution, valued the sessions as communal experiences resembling traditional healing rituals such as *Ndëpp*. In contrast, the Dutch participants, who were often affected by trafficking, substance abuse, and/or severe crises, appreciated the sessions as safe spaces for relief and self-expression. Despite these differences, in both contexts, music therapy fostered joy, solidarity, and reduced stress.
4. *Therapeutic value*: Music therapy aligned with the first phase of trauma treatment (i.e., safety, stabilization, and regaining control). While music therapy may not

[2] This method proved challenging for Senegalese participants unfamiliar with self-reporting emotions.

> resolve complex trauma, it contributes to trust-building, improvements in self-esteem, and readiness for more intensive therapeutic interventions.

Since 2008, I repeatedly reflected on the parallels and divergences between the Western music therapy practices in which I was trained and the *Ndëpp* healing ritual, which is predominantly practiced within the Lébou ethnic community in Senegal. In this essay, I aim to articulate these reflections and the questions that arose from it. My research trajectory generated a broad spectrum of inquiries, particularly through engagement with scholarship extending beyond the disciplinary boundaries of music therapy. This process unfolded in increasingly complex and non-linear ways, rendering the inquiry not only more challenging but also intellectually stimulating and profoundly enriching.

Towards an Integrative Framework: Connecting Senegalese Ndëpp and Western Music Therapy

During my project and review of existing literature, I encountered conceptual terrains in which definitions appeared fluid and boundaries less clearly demarcated. In the Senegalese context, practices are deeply embedded within societal and cultural norms, where the pursuit of rational or strictly causal explanations is not necessarily prioritized. Instead, engagement with phenomena that elude or resist European epistemological frameworks is both prevalent and accepted.

In attempting to navigate the space between the structured models of Western music therapy and the *Ndëpp* ritual, the significance of interdisciplinary perspectives became increasingly evident. In particular, insights from ethnomusicology offered a depth of understanding that extended well beyond what could be gleaned from music therapy literature alone.

Foundations for Cross-Cultural Comparison

Several elements from both the Senegalese and Western European contexts are outlined. These elements included: (a) mental health care in Senegal; (b) the Lébou ethnic group's social and cultural context; and (c) the *Ndëpp* ritual as a Bridge for reflection. These three aspects were the basis of my comparative literature review of the therapeutic and healing approaches.

Mental health care in Senegal

The World Health Organisation (WHO, 2024) defines mental health as follows:

> Mental health is a state of mental well-being that enables people to cope with the stresses of life, realize their abilities, learn well and work well, and contribute to their community. It has intrinsic and instrumental value and is integral to our well-being. (1st para.)

According to the WHO Mental Health Atlas (2020), there were 216 mental health professionals (i.e., psychiatrists, specialized nurses, psychologists, social workers and other professionals) in Senegal, equating to 1.33 practitioners per 100,000 people in a population of 16.3 million (WHO, 2020). As of 2020, the country had six psychiatric departments in general hospitals, four community facilities, three admission wards specializing in children and adolescents, and one psychiatric hospital. In 2020, the WHO reported 71,880 treated cases of psychosis in Senegal.

In 2019, the government formulated a mental health action plan, which included a law initially enacted in 1975, in addition to a national suicide prevention strategy. As of 2020,

efforts were underway to officially recognize traditional medicine within the healthcare system (Petit, 2020).

Historical accounts (Bullard, 2022; Lovell & Diagne, 2019) illustrate the influence of French colonialism on Senegal's psychiatric development, emphasizing the need to incorporate cultural considerations in mental health treatment. In the 1950s, the *Ecole de Fann* (i.e., *Fann's School*) was established in the *Hôpital de Fann*, the psychiatric hospital in the capital Dakar. Founded by the French military doctor Henri Collomb, the aim was to combine the social re-integrative processes of traditional healers with French approaches to curing neuroses and psychological illnesses. This approach was considered ethno-psychiatric and spread to other French-speaking African countries (Lovell & Diagne, 2019). Even then, hospitalized patients were not regarded as individuals detached from society; rather, their environment and fellow human beings were included in their treatment. The psychiatrists of the time also explicitly called for special attention to be paid to the role of the respective culture in the process of mental illness (Bullard, 2022). Later, however, Senegalese psychiatrists and intellectuals rightly questioned the colonialist roots of this model. Today, the approaches of that time have therefore disappeared from Senegalese healthcare. Only the hospital of the same name in Dakar still receives patients (Lovell & Diagne, 2019).

Regarding this historical development, Lovell and Diagne (2019) pointed out that Senegalese people distinguish between *faju Wolof*, which is Senegalese, traditional medicine, and *faju Toubab*, which is white, European, Western medicine. This illustrates that the possibilities offered by both medical systems are applied for the benefit of the individual, depending on the nature of the problem and on the person's social, financial, and societal position, as well as their surrounding context.

The Lébou ethnic group: Social and cultural context

Within a description of Senegal's broader mental health landscape, understanding the Lébou community—whose practices anchor the *Ndëpp* ritual—is crucial for grasping how traditional healing operates alongside biomedical approaches. The Lébou ethnic group is one of the many population groups in Senegal, most of whom live together peacefully. Due to immigration and the artificial demarcation of national borders during the colonization of Africa, representatives of this ethnic group also live in other African countries as well as outside the continent. The Lébou are known for their fishing livelihoods and strong adherence to traditional social norms. The community represents an important value authority that is very difficult to escape. Their cultural systems often take precedence over official laws and religious regulations (Sy, 2020).

The Ndëpp ritual as a bridge for reflection: Structure and functions

According to Accoroni (2006), the Western concept of "illness" corresponds to the West African concept of "injury." Here, one's integrity is attacked by an external force, which can be a spirit (i.e., "jiin"), witchcraft, or other analogous phenomena. Although an orthodox interpretation of Islam strictly rejects such ideas, the Islam practiced in West Africa and Senegal is open and accepting of local mystical practices and rituals. In a holistic view of health, both magical practices and herbal remedies for the protection of the person are accepted and embraced. Belief in these remedies combines aspects of religion with ancestral beliefs and traditional therapeutic approaches. The individual person is seen as less important than the community within which they live and by which they are supported (Accoroni, 2006).

According to Dorris (2011), mental health in Senegal is a product of both physical and spiritual aspects. *Ndëpp* is an animistic ritual that is primarily performed by Lébou women

(i.e., *Ndëppkat*). The aim of the ritual is to redeem the person possessed by a spirit (i.e., *rabb*). McKinley (2012) emphasized the mysterious and less public nature of these rituals. Thus, there are few existing written testimonies or other documentation of this traditional phenomenon. The ceremony is intended to heal mental and physical illnesses by repairing the relationship between the person concerned and their *rabb* (Dorris, 2011). This ceremony can be used both preventively and as a healing measure for an existing illness.

The *rabb* is a spirit with whom the ancestors of modern Senegalese families have made a pact. This spirit is supposed to protect the family for generations; in return, the family regularly sacrifices sheep or goats for the spirit. If this pact is disregarded by a family member of a later generation, bad things can happen to the family (McKinley, 2012). This can include, for example, an illness. Senegalese culture states that every person, regardless of their ethnicity, social status or nationality, has a *rabb*. According to Dorris (2011), the *rabb* can manifest itself negatively in three ways. First, it manifests as an inwardly felt presence that leads to pain or discomfort. Second, it manifests as an outward presence that affects the person's behaviour and speech. Third, the spirit completely possesses the person so that the person no longer consciously perceives themselves as human. This state is usually achieved during the *Ndëpp* ceremony.

Each *rabb* is associated with specific chants or rhythms that act as its respective signal or to which it reacts. They cause one to start moving and to act out their urge to possess a person (McKinley, 2012). When these specific chants are heard or the rhythms of drums are played, the person concerned falls into a kind of trance in return. Sudden, inexplicable changes in a person's nature and behaviour are primarily seen as a sign of the presence of an angry *rabb*. Members of the Lébou ethnic group are particularly respectful towards the spirits.

According to McKinley (2012), the attitude of interpreting scientifically inexplicable events or situations as the work of a spirit (i.e., jiin) continues to exist in Senegal today. In general, community healing and acceptance of mental disorders is much more central in Senegal than in Western societies. The entire community is also present at a *Ndëpp*, as the person affected is part of it. Western therapies, on the other hand, focus on the individual person and on clearly defined symptoms. Although traditional medicine is partly private, it also includes public aspects.

For a *Ndëpp* to take place, the affected person must be visited by a *rabb* in a dream. In this dream, the *rabb* explains how long the *Ndëpp* ceremony should last, when exactly it should take place, and what sacrifice should be made. Due to the extraordinarily high costs involved, such a ceremony rarely lasts more than a few days; however, the maximum duration can be up to eight days. More women than men take part in the ceremony, and family members of the person concerned identify themselves by wearing identical coloured clothing.

The first hours of the *Ndëpp* are the private part of the healing ritual, in which the person experiencing challenges and the healer are inside the house. After a few hours, more participants arrive and drumming begins. Apart from the female participants in the *Ndëpp,* the male drummers, most of whom are young, are the only men involved in the ceremony.

Following the first hours of the *Ndëpp*, chants begin. The *Ndëppkat* tries to crystallize the rhythms and chants appropriate for the *rabb* present. According to Dorrit (2011), two specific chants are suitable for each *rabb*: (1) a melody for calming and (2) an inciting, almost provocative melody. By observing the behaviour of the person concerned during the trance, the *Ndëppkat* can identify the *rabb* more precisely and thus set the healing process in motion. Dance is an important element throughout the ceremony. Finally, the offering takes place in a private context.

Europeans regard these and similar ceremonies as irrational, as spirits are conjured and involved in the ritual. Nevertheless, the *Ndëpp* plays a crucial role in the treatment of mental disorders in Senegal. According to McKinley (2012), conferences were held as early

as the 1960s with the aim of presenting traditional medicine and healing rituals to Western doctors and therapists. The socio-cultural environment of a patient, as well as the associated beliefs and rituals of a communal worldview, must not be ignored in the treatment of a suffering person. When these aspects are incorporated into the therapeutic process, they contribute to positive effects. However, if these rituals and belief systems, which are deeply rooted in Senegalese society, are denied, therapy processes will never be able to reach the person in their entirety (McKinley, 2012).

My own early experiences in Dakar highlighted this cultural gap. While I entered with a European model of music therapy, participants themselves described resemblances to the *Ndëpp*, suggesting continuities I had overlooked. This underscored the need for me, as a white, Western, therapist, to situate my work as one framework among many, often shaped by privilege and blind spots.

Defining Western Music Therapy

To examine possible bridges, it is essential to outline the foundations of Western music therapy. This contrast highlights how different worldviews shape therapeutic meaning and process. Music therapy, as I was taught, is relatively clearly defined. During both my music therapy studies and my practical music therapy work, it became a habit to orient myself using definitions. I also follow the rules that different schools of therapy prescribe for practical implementation in the therapeutic setting.

In the Western perspective, the music therapy process is based on the relationship between a client and a therapist. The medium of music is used, either receptively or actively, to analyse therapeutic needs and work towards clearly defined goals. In a thorough contribution, Mainka & Weymann come up with the following—new definition of music therapy:

> Music therapy is a scientifically based therapeutic discipline in which music interventions are applied to alleviate psychological, somatic, psychosomatic, and cognitive symptoms in a collaborative activity between therapist and patient. (Mainka & Weymann, 2025, p. 819)

The authors posit this definition to be of meaning to different actors and stakeholders of the health care sector. They explicitly claim its close link to the "bio-psycho-social understanding of illness and therapy" (Mainka & Weymann, 2025, p. 821).

Overall, the European music therapy community is characterized and enriched by numerous other schools, mostly derived from psychology and psychotherapy, depending on cultural circumstances and national and/or regional specificities. Each therapist's country of training also plays a role in the therapeutic trend that is favoured and the resulting therapeutic approach and working methods. What all Western music therapy schools have in common, however, is a certain set of rules, which provide guidance on basic approaches and the preferred methodology prescribed in practice.

Music Therapy within the Senegalese Context

According to Dorris (2011), music is an indispensable element of the Senegalese identity. Based on cultural influences in music and Stige's concept of community music therapy (Bruscia, 2014; Stige, 2002), one should include both one's cultural and community contexts in music therapy processes. Jebuni et al. (2020) also emphasized the importance of incorporating culturally specific principles when analysing and using music as a healing medium.

Concerning the Westernized definitions methods of music therapy, Dorris (2011) referred to the concept of medical ethnomusicology as an interface between ethnomusicology and music therapy. This places a stronger focus on cultural musical

aspects in the context of healing and recovery. However, research in this area is difficult because traditional healing ceremonies typically remain a secret and are not accessible to the public. Moreover, they usually encompass additional aspects including, but not excluding, dance and theatrical elements. Music cannot be extracted as the only medium affecting the suffering person. Cultural specificities therefore encourage us not to regard music merely as a universally effective medium. The rules, norms and modes of action that apply in the culture must also be analysed more closely.

Mental health is a community issue in Senegal. If a member of the community is ill, this affects all other members as well. Problems are shared; treatment is also not a private matter for the individual. After all, the treatment of a mental disorder should also serve the reintegration into society. Thus, music therapy in Senegal should consider the holistic view within traditional medicine and include the body as well as the mind, the soul, and the community in the therapeutic process. This could possibly also promote or facilitate the development of the discipline of ethno-music therapy (Dorris, 2011).

These considerations underscore the necessity of developing integrative curricula in music therapy education. Such training should not only cultivate interdisciplinary awareness but also actively promote therapeutic approaches that are integrative, multicultural, and intercultural in orientation. The aim would ideally enable practitioners to engage with the diverse life-worlds and social realities of the client populations they serve. Equally essential is the encouragement of sustained reflexivity among music therapists, particularly regarding their own positionality and the privileges, in order to foster therapeutic relationships that are less paternalistic and more egalitarian. From a personal standpoint, I now question whether adopting a less naïve, more critically reflective, and contextually relativized professional stance might have led to different outcomes in the field project I conducted in 2008.

Barriers to Cross-Cultural Integration

While these perspectives suggest fruitful directions for integrative practice, they also reveal structural and epistemological barriers that continue to impede cross-cultural understanding within music therapy. The following sections contain what I believe are essential considerations regarding an integrative, cross-cultural approach to music therapy. Inequalities and a prevailing intercultural imbalance should invite critical reflection on one's own positioning.

Inequalities within music therapy discourse

According to Norris (2020), Western music therapy is partly complicit in the "social death of Black people" (p. 2). She speaks of a "third worldness" (p. 3) within music therapy that consistently negates the narratives, contributions, and experiences of People of Colour. According to them, white supremacy is also real within the music therapy world, so that the experiences and needs of People of Colour—colleagues and clients alike—are not perceived or taken into consideration. Historically, since music therapy was founded by white people, contemporary music therapy is still primarily based on the values and ideals of white cultures. In the face of increasingly scientific and evidence-based work, indigenous traditions and ways of working are progressively seen as irrelevant and pre-existing inequalities are further reinforced.

The fact that music therapists rely primarily on relatively culturally limited literature poses a real risk for minority clients (Norris, 2020). Norris argued theories urgently need to be formulated in a culturally specific way and that science needs to include the community as context. They called for an equitable music therapy system within which it is no longer necessary to advocate for diversity, equity, and inclusion, as these would

already be inherent to the discipline. A system which represents colleagues, students, and clients with minority identities no longer requires affected individuals to raise their voices and fight for empowerment. Norris (2020) also warned against cultural appropriation within music therapy for People of Colour.

Ikuno et al. (2021) pointed out that many music therapists from non-Western countries and cultures are in danger of being silenced if music therapy continues to primarily prescribe to Western methods in practice and science as the golden standard. Valuable practical reports and culturally important aspects are lost, as they do not seem to fulfil the universally valid effects of music therapy. Music as a medium for healing and expression existed long before the formalized profession of music therapy (Ikuno et al., 2021). Yet today, these formal aspects are expected to guide what we do. This discredits culturally specific experiences.

Ikuno et al. (2021) also pointed out the risk of providing healthcare based on a framework from colonial times, especially for the treatment of communities that have suffered under colonization. The importance of specialized education and training in cultural competencies beyond white cultures is obvious. Here, whiteness should be analysed as a construct and its resulting oppression acknowledged. Such systemic realities affect indigenous communities and People of Colour and should be addressed by music therapists in practice and science as well as in music therapy training (Ikuno et al., 2021).

Post-Colonial Perspectives on Psychiatric and Global Mental Health

For decades, both scientists and specialists from the field of mental health care demonstrated non-European cultures were downplayed, criminalized (Beneduce, 2019) or pathologized. Beneduce (2019) also questioned the approach praised by the West as “improved access to treatment” (p. 713), as this is primarily equated with “improved access to psychotropic medication” (p. 713). They warned against the globalization of psychiatric diagnoses (Beneduce, 2019). Particularly in the case of Post-Traumatic Stress Disorder (PTSD), they questioned whether culturally specific interpretations and concepts are sufficiently considered. They critically examined the tendency to impose Western interpretations on other cultures, which promotes a globalized and, supposedly, universal view of psychiatric problems. They also raised concerns about whether the diagnostic criteria of the International Statistical Classification of Diseases and Related Health Problems (up to edition ICD 10) and Diagnostic and Statistical Manual of Mental Disorders (up to edition DSM 5) have been properly validated for minorities, in addition to non-Western communities and cultures.

Beneduce (2019) formulated the complex relationships between actors in the westernized healthcare system and traditional healers with their herbal remedies and spiritual-mystical rituals. The connection between health and culture is complex and multi-layered, and clear definitions are typically difficult to find.

Finally, Beneduce (2019) quoted the African psychiatrist Lambo who, as early as the 1960s, denounced Western psychiatry with its “moral arrogance” (Beneduce, 2019, p. 718) when it was thought that it could spread its categories and ideas universally and globally. They emphasized that this statement is still of great importance and should not be underestimated, especially in areas of refugee work and the care of migrants. In addition, West African healing traditions and rituals are now represented and practiced worldwide through migration processes in the diaspora (Monteiro & Wall, 2011). Not to do justice to this fact within therapeutic work, or to disregard these circumstances, would be tantamount to gross professional negligence.

Cox and Webb (2015) reminded us that the WHO’s Mental Health Action Plan (MHAP) 2013–2020 called for action to reduce the global burden of mental illness in all member states. The framework conditions for political action in this area need to be established

and existing services need to be improved. The MHAP aimed to ensure that low- to middle-income countries mirror current trends in high-income countries. The MHAP recognized that mental health is influenced by several environmental factors, namely political and social circumstances such as poverty, natural disasters, social and gender inequalities, and war. The objectives formulated in the plan relate to prevention as well as curative measures and rehabilitation. Even though the authors pointed out that, according to the WHO, these actions should be culturally appropriate (Cox & Webb, 2015), they critically examine and criticize the fact that the principles applied are nevertheless based on Western-influenced concepts and basic ideas. It is implicitly assumed that norms and values that are valid in the West, such as individuality, illness/health, and human rights can be transferred to countries in the Global South. According to Cox and Webb (2015), biomedical approaches are deemed superior to other approaches, which in turn corresponds to the view of Western psychiatric concepts. There is even a risk of "colonialist discourses" (Cox & Webb, 2015, p. 684) in mental health services.

I posit that culturally specific views and approaches must always be taken into consideration and included when treating a mental disorder. This includes an exchange with relevant local stakeholders and an analysis of the respective cultural specificities. Collaboration with local community leaders can contribute to high-quality work with highly positive effects for those affected (Cox & Webb, 2015). They believed the aspect of social inclusion in many cultures of the Global South can contribute to improved long-term effects and should not be underestimated in the therapeutic context. This compares to care in the Global North, in which affected individuals tend to live in isolation. This alters therapeutic integration and therefore leads to little chance for positive long-term effects.

Overall, the social context and its impact on mental health should receive more attention as it plays a crucial role, especially in cultures that place the community at the centre. Finally, Cox and Webb (2015) pointed out that the Western concept of "mental well-being" (p. 690) cannot simply be transferred to cultures in the Global South. The question arises as to what extent the Western-style evidence-based methodology can be adapted to local situations in a global context.

In retrospect, I critically acknowledge that I adopted a similar approach during my project. Specifically, I applied Western-derived concepts of disorders, problem areas, and potential solutions or improvements to the lived realities of Senegalese sex workers, without sufficiently accounting for the cultural specificities of their context. My positionality as a young, white, academically trained woman contributed to my uncritical acceptance of this framework, which was not explicitly challenged by the West African social workers actively engaged in the project. This dynamic points to an asymmetry of power between Western and West African actors. It further illustrates how, even within postcolonial settings and despite well-meaning—though at times naïve—intentions, colonial patterns and power relations can be unconsciously reproduced.

In reflecting on my 2008 study, the question emerges as to what outcomes might have been realized had Western psychiatric and psychological frameworks been de-centred, and West African healing concepts instead served as the guiding paradigm of the project. Such a shift could potentially have generated alternative possibilities for practice and understanding. Nevertheless, my positionality as a young, white, Western woman would, likely, have limited access to these culturally specific ritual practices.

Since healing rituals are reserved to traditional healers, I thus raise the question of how we, as music therapists, can collaborate, or create synergies, to provide our clients with the most culturally faithful and integrative treatment possible. In retrospect, such collaboration might have led to more far-reaching results in my 2008 study. These critiques underscore the necessity for reflexivity in my own practice and writing. It is from

this awareness that I turn, finally, to outline the integrative perspective that has emerged from this journey.

Towards an Integrative Perspective

In this essay, I originally wanted to analyse the differences and parallels between the Western music therapy and the Senegalese healing ritual, *Ndëpp*. From this synthesis, I hoped to formulate concrete points of contact for music therapists. After studying numerous specialised articles from the fields of music therapy, psychiatry, sociology, and ethnology, I identified the building blocks that define and characterize both Western psychiatry/psychotherapy and Western music therapy. I am also now able to shed light on culturally specific elements of the treatment of mental disorders in Senegal. Nevertheless, the review of the extant literature led to new questions rather than providing clearly defined instructions for Western music therapists.

Ultimately, the bridge-building I had initially envisioned unfolded in unanticipated ways. Nonetheless, the establishment of connections between structured Western music therapy and the Senegalese *Ndëpp* healing ritual—as well as comparable traditional and culturally embedded practices from other regions—appears both possible and, in fact, urgently necessary. Considering contemporary global crises, including conflicts, natural disasters, and other circumstances that force individuals to leave their homelands—often under profoundly traumatizing conditions—therapeutic practices, including music therapy, must be approached in a culturally sensitive and culturally informed manner.

From my perspective, critical reflection on one's own privileges constitutes an essential component of an ethically responsible therapeutic stance. Such reflexivity forms the foundation for authentic and egalitarian relationships between therapist and client. Moreover, I believe that engaging in a dialogue about Western theories, definitions, rules, and methods, in addition to recognizing the beliefs, rituals, traditions, and conceptions of personhood held by those we work with, enhances the effectiveness of therapeutic processes and fosters relationships that are more genuine, equitable, and ethically sound. This stance grew directly from my own experiences. As a young white student in Dakar, I introduced drumming in therapeutic sessions, only to be shown by the women themselves how music already carried healing power. Their comparison to the *Ndëpp* ritual taught me that any attempt at bridge-building must begin with humility and acknowledgment of my situatedness. My interpretations remain partial, but I assert that naming this positionality is essential for authentic cross-cultural dialogue.

White music therapists should actively seek out the voices of colleagues and clients of Colour and listen to them with undivided attention. Only in this way can we contribute to equality and fairness within our discipline and avoid and prevent (re-)traumatization due to power inequalities. Without opening our therapeutic stance, the traditional view seems to be constricted, limited, even monotonous. The psychiatrist Henri Collomb (1931–1979), the French founder of the *Ecole de Fann,* emphasized the importance of transcultural psychiatry and ethnopsychiatry in his writings of 1979. I believe we can achieve a broader perspective that expands our scope of action in the music therapy context and thus enables and even strengthens therapeutic success. In Bullard (2022), Collomb said:

> I've been in Africa for many, many years and I've let myself be contaminated. Certain of my colleagues would say that I've lost all scientific judgement and adopted superstitions. Well, I think also that I've reflected long on what goes on around me, and the approach of the healers invited me to think that perhaps something else other than science exists, that explains some types of healing. (Bullard, 2022, p.38)

This quote, which partly inspired me to write this essay, demonstrates both a torn feeling in addition to a reflective and relativizing attitude. It thus reflects my own thoughts and feelings, 17 years after having conducted my own practical, culture-comparative music therapy project in Senegal and The Netherlands. Based on critical yet essential reflexions and self-questioning, I would therefore like to formulate the following practical implications for music therapists as concluding considerations:

First, white music therapists should critically examine their positionality and privilege, recognizing that their training, methods, and assumptions are deeply rooted in Western frameworks that carry implicit authority in cross-cultural contexts. This requires acknowledging that their knowledge is not universal but culturally situated. Entering therapeutic or research relationships without this awareness risks reproducing colonial hierarchies, in which Western models are treated as inherently superior or "scientific," while non-Western practices are dismissed as "folk" or "irrational."

Second, the risk of cultural appropriation must be taken seriously. Rituals such as the *Ndëpp*, and similar practices, cannot simply be "borrowed" or transplanted into music therapy sessions. For white practitioners, using elements of these traditions without deeply understanding and honouring their spiritual, communal, and historical contexts can reduce them to aesthetic tools stripped of meaning. The ethical responsibility lies in resisting appropriation and instead learning how to work alongside—not over—cultural traditions. This also requires a commitment to listening and decentring. White therapists must actively shift focus away from their own frameworks and instead amplify the voices of colleagues and clients of Colour. Rather than asking, "How can I use this ritual or music in my work?", the more ethical question becomes, "How can I create therapeutic spaces where cultural practices already meaningful to clients are respected, supported, or integrated through collaboration with local healers and communities?"

Finally, there must be ongoing critical reflection on clinical tools (i.e., standardized measures and therapeutic instruments developed within Western psychology- such as PTSD scales or self-report questionnaires—which often fail to capture culturally relevant experiences of distress in non-Western contexts). My own experience with the Smiley scores in Dakar highlights this lack of connection. White therapists must therefore examine whether their assessments and interventions are culturally valid, or whether they risk imposing foreign categories of suffering onto people whose realities do not align with these frameworks.

Final Thoughts

For equity to be possible in music therapy education, practice, and research, I would like to suggest further reflexion on the hereby described processes. First, decolonizing training and literature are essential steps toward equity in music therapy. Music therapy education must diversify its curriculum to include Indigenous, African, Asian, and diasporic perspectives. Currently, the field is overwhelmingly shaped by white, Euro-American voices. For true equity to exist, theories and practices from marginalized cultures must not be treated as mere "add-ons" but as equal and valid knowledge systems in their own right.

Second, collaboration with local healers and communities is another key element of equitable practice. Rather than positioning Western therapy as the default framework, music therapists must engage in genuine partnerships with traditional healers, community leaders, and cultural practitioners. In contexts such as Senegal, this means working alongside *Ndëppkat* (ritual leaders) where appropriate—not in competition with them, but in mutual respect and shared purpose.

Third, structural change in the discipline is also urgently needed. White supremacy in music therapy is not limited to individual practices—it is embedded in the systems that govern the field. Journals often privilege English-language, Western research; funding

bodies tend to overlook community-based or Indigenous approaches; and institutions frequently gatekeep what is considered "valid" therapy. Achieving equity requires dismantling these systemic barriers so that practitioners and clients of Colour are not continually forced to justify or advocate for their inclusion.

Fourth, accountability and ethical practice are ongoing responsibilities for white music therapists. It is imperative to acknowledge when their practice risks perpetuating harm, remaining open to critique from colleagues of Colour, and committing to a process of lifelong unlearning. Ethical practice also involves rejecting universalist claims—such as "music is healing everywhere in the same way"—and instead embracing the complexity and plurality of how healing is understood and experienced across cultures.

Fifth, humility as practice is foundational. Equity in music therapy will only be possible when white therapists approach cross-cultural work with humility and recognize that they are guests in other traditions, not gatekeepers. This requires slowing down, resisting the impulse to define or categorize, and intentionally make space for "other ways of knowing" to exist on equal footing within the therapeutic encounter.

Conclusion

This essay drew on an interdisciplinary body of literature from music therapy, ethnomusicology, sociology, and psychiatry to examine the intersections and tensions between Western music therapy and the Senegalese healing ritual *Ndëpp*. It highlights that conceptions of healing, personhood, and mental health are culturally situated rather than universal. The objective was to critically revisit my music therapy project conducted in Senegal in 2008 and to reflect on how Western frameworks—shaped by privilege and colonial legacies—both enabled and constrained intercultural therapeutic engagement.

My findings indicate that although significant parallels exist—notably in the use of music, rhythm, ritual, and collective participation—fundamental differences persist, particularly the Western emphasis on individual pathology as opposed to *Ndëpp*'s community-oriented and spiritual focus. These divergences reveal the limitations of applying Western diagnostic categories and assessment tools in non-Western contexts and underscore the risk of reproducing epistemic imbalances and unequal power relations.

Based on these observations, I recommend that White music therapists adopt a stance of sustained reflexivity, cultural humility, and ethical responsibility; actively decenter Western paradigms; resist forms of cultural appropriation; and engage in authentic collaboration with local healers and communities. Such an approach fosters more equitable, culturally grounded, and context-sensitive therapeutic practices—especially necessary in an increasingly globalized world shaped by migration.

About the Author

Cathy Schmartz is a psychologist and music therapist based in Luxembourg, Europe. She currently works in a care home facility as well as in private practice. Her work focuses on psychotrauma in children, adolescents, and adults. Her professional interests also include intercultural dynamics in therapeutic contexts, as well as questions of privilege and positionality—particularly in her role as a white, European, university-educated woman—and the ethical implications that arise from these. She is actively engaged in ongoing reflection on accessibility and equity in the field of music therapy and regularly gives workshops and lectures on the conscious use of music in institutional settings such as schools and care facilities.

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