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Remembering the patients on the sesquicentennial anniversary of the Fort England Psychiatric Hospital

Rory du Plessis

School of the Arts, University of Pretoria, Hatfield, Pretoria, South Africa

ABSTRACT

In 2025, the Fort England Psychiatric Hospital celebrates its 150th anniversary and this marks it as the oldest South African psychiatric facility that is still in use today. Over its many years of existence, the hospital's history and heritage has been synonymous with the careers of the appointed medical superintendents. Thus, the dominant heritage discourse of the hospital commemorates the achievements of the medical superintendents, but what is missing from the heritage of the hospital is the patients' experiences and stories. In this article, I seek to include the experiences and stories of the patients as central narratives in the memorialisation and heritage of the hospital. To retrieve aspects of the patients' lives and experiences, I investigate 20 case files from a set of 200 that was recently discovered at the hospital. The entire set of case files is composed solely of white male patients, who were suffering from chronic mental illness and who remained institutionalised until their passing. A mad studies framework, which aims to humanise the patients, guides the investigation of the case files. Accordingly, the article contributes a humanised narrative of the lives and experiences of the chronic patients to the heritage of the hospital.

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Introduction

The Grahamstown Lunatic Asylum opened on 9 September 1875 and this year, 2025, marks its 150th anniversary. The institution is now known as the Fort England Psychiatric Hospital and its anniversary marks it as the oldest South African psychiatric facility that is still in use today. The hospital, which is situated in Makhanda, in the Eastern Cape Province, remained from 1875 to 1960, a relatively small institution with patient numbers of approximately 240 in the early 1900s and rising to approximately 700 in the late 1960s (Minde 1974, 2231). Over its many years of existence, the hospital's public history and heritage have been synonymous with the careers of the appointed medical superintendents:

> Many of the best-known medical superintendents in the [South African] mental service have . . . won their spurs at [Fort England] . . . Three later Commissioners of Mental Health served there as medical superintendents, namely Dr P. J. G. de Vos, Dr I. R. Vermooten; and

CONTACT Rory du Plessis rory.duplessis@up.ac.za School of the Arts, University of Pretoria, Private Bag x 20, Hatfield, Pretoria 0028, South Africa

> Dr B. P. Pienaar. Other well-known psychiatrists who have been in charge there included Dr K. Gillis, Dr I. F. A. de Villiers and Dr D. S. Huskisson. (2231)

The doctors cited in the quote pertain to those who worked in the twentieth century, but in the nineteenth century, the hospital's second medical superintendent, Dr Thomas Duncan Greenlees, was lauded by the national and international medical community for the direction and character by which he administered the hospital during his tenure from 1890 to 1907 (Du Plessis 2020). While the history and heritage of the hospital commemorates the medical superintendents, the experiences and life stories of the hospital's patients are absent. Consequently, to date, the patients of the hospital have neither been remembered nor commemorated.

The exclusion of the experiences of the patients in the hospital's heritage and history is not unique to the institution, as multiple studies (Carnemolla and Steele 2024; Punzi, Singer, and Wächter 2025; Reaume 2000, 2024, 2025; Rodéhn 2024) have underscored how 'patients' experiences and histories are marginalised in [the] cultural heritage' (Rodéhn 2024, 960) of psychiatric institutions. Owing to the marginalisation, neglect and exclusion of the patients voices, scholars have embarked upon research that places 'patients as central for remembrance' (Punzi and Lindbom 2025, 35), and the inclusion of their narratives and experiences as underpinning the heritage of psychiatric institutions (Carnemolla and Steele 2024, 1336). In this article, I seek to restore the experiences and narratives of the Fort England Hospital's patients to the history and heritage of the institution. To do so, I investigate a sample of 20 case files from a set of 200 that was recently discovered in one of the hospital's cabinets and are now in the custody of the Cory Library, Rhodes University (Van Zyl 2018, 3). Although the case files prioritise clinical narratives of disease and pathology, they also contain the doctors' candid descriptions of the patients, some of the patients' biographical details and information on their family connections, as well as 'glimpses into the perceptions and viewpoints' (de la Cour and Reaume 1998, 243) of the patients. In this sense, although the contents of the case files are insufficient to provide either a biography of the patient or a comprehensive first-hand account of their views and voice, they contain faint but valuable details that are 'essential for humanizing' (Reaume 2000, 98) the patients.

The entire set of 200 case files are composed solely of white male patients, who were suffering from chronic mental illness and who remained institutionalised until their passing. While the set of case files constitute only a small portion of the hospital's total admissions, and while they do not present the hospital's heterogeneous patient body in terms of race and gender, they are significant for recording the entire period of the patients' institutionalisation: the patients were admitted between the late 1890s to the early 1900s and periodical entries were recorded until the patients passed away – in some instances, this was late into the 1950s. Prior to the discovery of the case files, we only had the hospital's casebooks, housed at the Western Cape Archives and Records Service, which contained reports from 1890 to approximately 1918. In investigating the case files, I follow Coleborne's (2015, 185) suggestion that a diagnostic category is as important as notions of age, gender, race and class when understanding how patients were labelled, grouped and treated by psychiatric facilities. Thus, the focus of this article is on the lives and experiences of patients who were diagnosed with chronic mental illness. The importance of addressing this focus area is substantiated when we recognise that in

many of Greenlees (1896, 1905, 1907) publications he disseminated a dehumanised account of chronic patients.

In investigating the case files, my work is informed by a mad studies perspective on heritage that aims to memorialise the lives of those who were institutionalised in psychiatric facilities (Reaume 2025, 98) and to include their experiences and stories in the history of psychiatric facilities (Rodéhn 2024, 956). Rodéhn (2024, 964) has eloquently articulated a full-length account of adapting mad studies within the field of critical heritage studies and has outlined 'mad studies as a methodology and developed mad reading as a method for heritage studies', as entailing a 'shift of perspective from psy-science-influenced research to a mad-centred way for studying cultural heritage, allowing for an open definition of madness, not limited to diagnoses and psychiatric labels'. Central to Rodéhn (2024, 964) thesis is that different aspects of the heritage of psychiatry require 'different approaches as well as different methods'. In investigating the hospital's case files, my approach is guided by the central tenets of mad studies and is closely informed by the theoretical contributions of Geoffrey Reaume.

Mad studies for Menzies, LeFrançois, and Reaume (2013, 13) 'takes as its principal source, inspiration, and raison d'être the subjectivities, embodiments, words, experiences, and aspirations' of those who were institutionalised. To this end, the focus is on resurrecting the 'lost voices' and 'lost experiences' (Reaume 2018, 28) of the hospital's patients by exploring how the subjects were oppressed by the psychiatric institution, how the clinical labels acted to 'pathologize and degrade' (Menzies, LeFrançois, and Reaume 2013, 10) their identity, as well as how the subjects expressed agency (1). These tenets of mad studies are weaved into the four sections of this article. The work of the mad studies scholar, Geoffrey Reaume, is a central underpinning of this investigation, as his work engages with topics of memorialisation, and the heritage and histories of madness. Reaume (2000, 98) calls upon researchers to give the 'person with a mental disorder an identity beyond their "madness"', as this attribution is 'essential for humanizing and making visible' their lives, experiences and stories. In heading his call, I identify the patients of the hospital by their first names (Reaume 2018, 35) and underscore how their 'lives were far more complex, rich and meaningful than an approach which subsumes them under the anonymous label of diagnostic categories' (Reaume 2000, 100). To this end, I include substantial evidence from the case files to explore the voice and experiences of the patients. However, rather than repeating the same case file reference after each quotation, I have opted to only cite the reference once in each of the article's sections. Finally, as the article seeks to offer a 'respectful, and critical, interpretation of the lives' (Reaume 2018, 28) of the patients, I have followed Reaume's (2018, 28) decision to include information that does not degrade or disgrace the memory of the patients.

In the first section, I provide a counter-narrative to Greenlees's clinical portrait of patients with dementia and chronic mental illness. In Greenlees's publications, he made use of cases from the hospital to illustrate the main features of dementia and chronic forms of insanity. He presented patients with chronic insanity to have minds that 'will become more and more enfeebled, until the darkness of mental death over-shadows' them (Greenlees 1907, 10), while demented patients were depicted to have a mind that was 'dead' and thus to be incapable of experiencing 'pleasure or enjoyment in this life' (22). Yet, in scrutinising the case files, we are presented with cases that stand at odds with Greenlees's published account. Thus, the case files provide evidence to counter Greenlees

clinical portrait, and in pursuing the investigation, I am able to offer a narrative of chronicity that is based on the lived experiences of the patients. The pursuance of this investigation is aligned with the aim of the article that seeks to broaden the heritage of the hospital to include patient-centric experiences of chronicity. Accordingly, my interest is not in ascribing Greenlees's views to be indicative of the nineteenth century zeitgeist, but rather on incorporating into the hospital's heritage the experiences of the patients who lived with chronic mental illness. Complementary to this interest, I explore how the lives of the patients were meaningful, and in doing so, I add positive stories to the historical memory of the patients. This aim is informed by Reaume (2024, 31) who critiques how sanism depicts the mentally ill 'solely through a negative lens' and is manifest in the framework that equates being mad as synonymous with being incapable and sick, helpless and hopeless.

In the second section, I explore how the doctors 'reflected upon, counted, described, [and] understood' (Coleborne 2015, 84) the patients. Overwhelmingly, the doctors provided curt periodic reports that detailed the patients' mental and physical conditions, their conformity to the hospital's rules and regimen, and their ability to execute work duties at the hospital. Thus, the case file entries are largely concerned with the doctors reporting of the men in terms of their 'patient-hood' (Wilbraham 2014, 169): their illnesses, their docility and discipline, and their work performance. My discussion of the representation of patient-hood in the case files is divided into two parts. In the first part, I investigate how the doctors appraised the patients based on their work performance. The doctors prized patient labour as integral to the therapeutic and economic imperatives of the hospital. To elucidate, the labour performed by the patients was believed to hold therapeutic intent by keeping the patients occupied and offering an outlet for the patients to expel and expend their energy (Du Plessis 2020); and an equally important role of patient work was that it made it possible for the hospital to reduce its expenditure on labour (see also Reaume 2006). The docile and industrious patients received the praise of the doctors, but there are instances in which the patients resisted working (see also de la Cour and Reaume 1998). Although such acts were scorned by the doctors and resulted in the doctors writing disdainful accounts of the patients, I read these 'against the grain', as expressions of the men's acts of agency and as a means for us to glimpse their experiences and responses to the hospital's 'massive system of economic exploitation of inmates' (Reaume 2025, 98). In the second part, I examine how the doctors' interviews with the patients focused on recording their voice in terms of their confessions of mental illness. Consequently, the patients' voice was valued for exhibiting self-confessions of insanity. As a means to restore the patients' voice to enunciating aspects of their subjectivity and agency, I explore the men's power struggles with the doctors and their resistance to the hospital's rules and regimen. To bring further into view their impressions, experiences and subjectivity, I explore the men's self-led leisure pursuits. One central focus area is how religion was an important aspect of some patients' sense of self.

In the third section, I focus on the case files of migrants and immigrants who were recent newcomers to the Cape and thus I build upon the theme of migration and mental health history (Coleborne 2015; McCarthy 2015; McCarthy and Coleborne 2012; Swartz 2015). The Cape did not have a full-scale repatriation programme for insane migrants and immigrants (Swartz 2015), and this meant that those who were diagnosed with

chronic forms of mental illness would remain institutionalised in the Cape. This was the case for the four men I discuss who remained inmates at the hospital until their death. In the discussion of the case files, I highlight how the foreign tongue spoken by the men posed a problem to the doctors in ascertaining their mental state and in meaningfully communicating with them (see also McCarthy 2015). Instead of seeking to cross the language barrier with the aid of employing professional translators, the doctors appeared to be more interested in how the men were able to follow simple instructions to execute work duties. Consequently, the case file entries are chiefly concerned with characterising the men in terms of their ability to perform productive labour. Overall, owing to the focus in the periodical entries on the men's labour, and coupled with the incompleteness of their admission records, an appreciation of the men's personhood and a glimpse of their life story is therefore not possible in the hospital's case files but I propose that this may be possible by tracing records for the men from international archival and genealogical sources.

In the last section, I explore how families sought to maintain connections with the men by corresponding with the doctors on a range of topics. The study seeks to build upon a scholarship that explores how families actively participate in the treatment and care of their relatives at institutional sites (Coleborne 2010) while also highlighting the narrative patterns in the letters exchanged by the doctors and the families (Coleborne 2006). The dominant narrative pattern in the doctors' letters enumerated on the men in terms of their patient-hood, but in the letters from the families, the dominant narrative pattern is how they upheld the personhood of the men.

In sum, by adopting a mad studies framework and by building upon the scholarship that underpins the four sections, the investigation of the case files reveals the stories of the patients, as individuals. To this end, the article's main contribution is incorporating a humanised narrative of the lives and experiences of the chronic patients into the heritage of the Fort England Hospital.

Counter-narrative of dementia and chronic mental illness

Greenlees delivered a diagnosis of dementia in patients suffering from chronic mental illness when they presented a loss of cognitive ability. In this sense, Greenlees deployed the diagnosis to refer to chronic psychosis in patients from any age group who showed cognitive difficulties (see also Hill and Laugharne 2003). In his articles, Greenlees characterised patients with dementia as having the 'absence of mind' to be subsided into 'fatuous mental degeneration' (Greenlees 1907, 20) or to have 'permanently deadened' (Greenlees 1896, 20) mental faculties. Accordingly, Greenlees presented their institutionalisation at the hospital to be typified by them remaining 'hopelessly sick' and incapable of expressing or experiencing 'mental pleasure or enjoyment in this life' (Greenlees 1907, 22). Greenlees thus disseminated a dehumanised account of the patients by presenting their minds, interests and individuality as 'dead' (22). In the case files, we are offered evidence to offer a counter-narrative to Greenlees's clinical portrait of dementia, as the patients did not remain in a state of mental incapacity and did not exhibit a permanent loss of interest in life. By exploring this evidence, we are able to call for a revised narrative of chronic mental illness that is informed by the lived experiences of the patients. More broadly, we are also able to appreciate how chronic patients are not

to be thought of as 'ill identities' (Parr 2008, 22) but as individuals who lived a meaningful life.

Arthur (age 29) was described in 1905 to be 'sinking into a quiet dementia' and was deemed to lack the 'power of initiative and reasoning' (PR 10360/73). Nevertheless, in the following year, he 'successfully engineered and carried out an escape', which was motivated by his intention to visit the hotel where he worked as a barman. Although he was apprehended and brought back to the hospital on the same day, this did not deter him from pursuing, over several years, five further escape attempts. In one escape attempt, he managed to get almost 100 km away from the hospital and eluded the authorities for close to a week. The escape attempts present evidence that contradicts the doctors' initial assessment of him to be 'incapable of any form of mental effort', as he was successful in unwitting and outsmarting the attendants to determine the best time and location to make a run from the hospital. In 1909, Elliot (age 31) was deemed to be 'drifting into dementia', and in 1913, he was said to be 'quiet and depressed and associated with no one' (PR 10360/121). Yet, in the 1920s, his condition improved to such an extent that he returned to practicing his former trade, a barber, and cut the hair of the patients and showed a remarkable degree of 'insight for the other patients'. Significantly, until early August 1948, he continued to work as a barber, and he remained 'cheerful and contented with good preservation of his personality'.

Six years after his admission in 1899, Timothy (age 52) was diagnosed with dementia and from 1905 to 1914, he was said to live a disinterested life where he 'does nothing useful; keeps aloof from the others as a rule' (PR 10360/20). In 1915, the doctors marvelled that his 'demented state' was waning, as he correctly informed a doctor of the date of his admission and that he knew 'that there is a big war going on at present'. His mental acuity was again highlighted in 1919 when a doctor concluded, 'He is correctly orientated, shows no defect of memory and can give a fairly clear account of himself. Has a fair knowledge of current events'. Later in 1924, at the age of 71, his 'memory and orientation' remained exceptionally good. For Jeremiah (age 24), the doctors declared in 1896 that he was suffering from dementia and was 'dull, depressed and confused', yet in the early 1920s, in his conversations with the doctors, he was found to present 'no marked memory defect' and was commended for showing 'lucid comprehension, will give a clear account of himself before and since admission' (PR 10360/13).

In the examples discussed, the patients' lived experiences of chronic mental illness stand in contrast to how Greenlees presented the 'pathology of the disease' (Greenlees 1905, 219) as synonymous with the patients living in a state of perpetual mental vacuity and incapacity. For the patients under investigation, their chronic condition was marked by moments of improved mental health and mental acuity. This finding is in resonance with Parr's (2008, 21) call for chronic mental illness to be conceptualised in terms of 'flux' between periods of improvement and relapses, as well as conceived as a 'nonlinear, complex patterning' (Parr 2008, 22) that defies simplistic reductionism to a predetermined models of illness progression. In adopting Parr's consideration, my interest is not only to rewrite the narrative of chronic mental illness in terms of 'flux' but also to appreciate how the institutionalised life stories of the men featured qualities of 'recovery', with recovery in this sense pertaining not to cure, but to how a patient is able to live a meaningful life – that incorporates elements of hope, change and agency –

despite continuing to experience symptoms of ill health (Parr 2008, 22). In this regard, recovery is inscribed in Arthur's interest to visit his former place of employment, in Elliot's newfound interest in his fellow patients and offering them his barbering services, and in Timothy and Jeremiah's mental acuity and preservation of their memory.

The discrepancies between the hospital's case files and Greenlees's published case histories underscore how Greenlees did not aim to present an accurate clinical case history of chronic insanity but rather presented a stigmatised image of chronicity to stimulate public advocacy of eugenics. To substantiate this, Greenlees authored the periodical case file entries that reported on the chronic patients' regained mental acuity, as well as their achievement, progress, capacities and capabilities, but in his publications, he cited none of these facts. Instead, he upheld a dehumanised account of the chronic insane as 'hopeless' and mentally 'dead' (Greenlees 1907, 22). In presenting a pathologised portrait of chronic insanity as 'hopeless incurables', Greenlees (1907, 22) primed and incited the public to 'realise the enormous burden they are called upon to bear in the maintenance' of the patients. 'When this fact is fully realised', Greenlees lauded that 'a new dawn is imminent in the history of our race', which will include the 'elimination of the chronics from our Asylums' (Greenlees 1907, 22) and the adoption of

> temperance, hygiene and the laws that govern heredity . . . until we see the results in a new race, healthy in mind as well as in body. Such results the Church, as well as our schoolmasters, might assist in bringing about, and where teaching fails, then legislation should assist the medical men in forcing people into grooves, whose ultimate goal is *mens sana in corpore sano* (Greenlees 1907, 23).

In cognisance of Greenlees's texts presenting a stigmatised caricature of the chronically insane to advance his eugenic advocacy, the findings of this section serve to restore the humanity of the patients and liberate the 'buried histories' (Reaume 2018, 32) of how the patients lived a meaningful life. Overall, the findings provide positive stories for inclusion in the public memory of the patients.

Testimonies of patient-hood and the voice of the oppositional patient

The majority of the periodical entries in the case files are one-liners in which the doctors report on the patients in terms of their behaviour and conduct, their work duties, and their physical and mental health. By way of example, John's case file entry for September 1910 stated, 'Seems more demented . . . Doesn't do so much work now', and a later entry simply indicated that he is 'Much more demented – his work is almost nil now' (PR 10360/25). To understand why the entries make repeated reference to a patient's ability to work, it is important to underscore that once the doctors diagnosed the men as a chronic case of insanity and therefore holding no prospect of recovery, their reporting focused on the use and value of the men as an unpaid workforce. Consequently, the case file entries focus less on the mental condition of the patients but on the character of the men as a labourer, with the description of a 'good worker' entailing that they could 'work well and usefully' (PR 10360/21), were 'willing, agreeable and industrious' (PR 10360/71), as well as 'obliging' (PR 10360/10).

In the case files, there are a handful of entries that contain fragments of the men's responses, struggles and resistance to being an unpaid labour force. By exploring these

fragments, we can bring into view the agency of the men rather than the upholding the dominant narrative of the case files that portrays a docile-drone-like caricature of the men as, 'well behaved and works well' (PR 10360/21). Jeremiah was commended for his work in the dining-hall, but it soon became clear to the doctors that there was a 'method in his industriousness', as he would select the best meals for himself (PR 10360/13). James worked in the hospital's printing room and after working there for 2 years where he did all of the printing 'without any help', he began to demand compensation for his labour (PR 10360/82). At first, he liked to receive a 'beer for any work he does' but later he demanded financial payment. James levelled a 'No pay, no work' argument to the doctors, and declared that he 'won't work for nothing and has no desire to be in this bloody [jail]'.

While the majority of the case file entries are composed of curt reports that catalogue the docility and productiveness of the patients, there are a handful of cases where some of the entries are longer and report on the doctor's interviews with the patients. These interviews reported on the degree to which a patient showed insight into their condition, if any psychopathologies could be identified, and the purported reasons why a patient was not engaging in work activities. For example, in 1920, following an interview with Jeremiah, a doctor noted that he

> Is fairly well orientated and shows no marked memory defect . . . gives present date correctly. Has done no work for the past two years . . . says he has been too weak – cannot state how he feels weak and there is no apparent bodily disorder. Is quite comfortable here and has no desire to leave – 'what would I do outside?'. Is inert, disinterested and unsociable. Almost daily he has noisy outburst of swearing – denies hallucinations but admits these attacks 'I get swearing sometimes – I am in agony – I can't stop it, I've tried to. It is because I'm mad – I must be mad if I've been here 23 years. I'm not fit for this world'. (PR 10360/13 n.d.)

Here, Jeremiah's direct voice is quoted only in terms of labour and his patient-hood: a self-confession and self-recognition of his madness. In an interview of the following year, we again see that Jeremiah's voice is tied to his patient-hood: the doctor records that Jeremiah acknowledges that after many decades of asking for his discharge, every doctor stated to him, 'I was mad – therefore I must be mad – not very mad – but mad enough not to go out again'. In the sample of case files investigated, all the interviews demonstrate the patient's direct voice as anchored to their patient-hood. For example, the doctors found Elliot to be correctly 'orientated for time, place and surroundings and gives a good account of himself' but they only record his direct voice when it pertains to his confession of delusions, namely that 'evil spirits' persecute him (PR 10360/121). In sum, in the interviews with the patients, the doctors' questioning included asking patients to give an account of themselves 'before and since admission' but their responses to this request were unrecorded. In the instances in which the patients' voices were recorded, these were limited to confessions of what was 'mentally wrong' (PR 10360/20) with them, and why they were not working.

Although the interviews provide us with only the voice of the men's patient-hood, there is a possibility to read the case file entries 'against the grain' in order to gain glimpses of the personhood of the men. To explicate, the case files contain numerous entries where the doctors reported on aspects that aggrieved them about the patients, including their opposition to the hospital's regimen, their preferences for leisure interests

above working, their likes and dislikes, complaints and convictions. The aspects that were framed as a source of annoyance by the doctors can be reframed as instances in which the men resisted the authority of the doctors and rejected the hospital's regimen, and thereby asserted their agency and individuality. Charles frustrated the doctors, as he never tired of recounting to them of his achievements in playing cricket. Here, we see Charles as an individual who 'reminisces a good deal' and who enjoyed 'relating his own exploits' in his life before the hospital (PR 10360/71). Though we have no more details to add to these fragments, they remain valuable for allowing us to perceive him as an individual with accomplishments on the cricket field, rather than simply the doctors' depiction of him in terms of his patient-hood, as one who 'wears a silly grin, and shows no real insight into his condition'. Norman was characterised over several entries to be on a 'downward course . . . mentally and physically' and to have a 'very defective' memory (PR 10360/9). Nevertheless, Norman's strength of will remained resolutely intact, as when he did not receive what he considered a sufficient ration of food, he would refuse to eat. Furthermore, he would often complain of the 'filthy food' served at the hospital that is 'not fit for a dog to eat'. These few lines allow us to perceive how Norman resisted ingesting the hospital's standardised diet scale and food that was unappetising.

The hospital ran a regimental daily routine in which the patients were expected to abide by. In many ways, whether it was work or leisure, dining or sleep, all were governed by set times, conducted in designated areas, and were standardised for large patient groupings. Nevertheless, there are several references in the case files of patients who rejected the hospital's recreational activities and entertainments and instead went about 'creating their own forms of recreation and leisure' (de la Cour and Reaume 1998, 249). Accordingly, these instances are valuable for providing a perspective of patient life and experiences that was a product of their own 'self-initiated' leisure pursuits and interests (252).

In 1912, Frederick, as a paying patient, received the privilege of a private room that quickly became a 'collection of all sorts of things', including a gramophone and records, 330 books, and files containing his correspondence and writing (PR 10360/45). Frederick detested leaving his room and opted to spend a good part of the day in his room reading, drawing, painting, arithmetic and writing. Even during meal times, he was allowed to 'carry food from the dining-hall to his room'. In his room, he loathed any interference from the doctors, as he wished 'to live in his own sphere . . . undisturbed'. It is possible to argue that Frederick forged his room, as a personal sanctuary where he was able to 'find solace' (de la Cour and Reaume 1998, 250) from the hospital's regimen, as well as nurture and pursue his personal interests and preserve his self-image. The privileges granted to him in the early 1910s became a thorn in the side of the doctors of the 1920s who stated, 'He has been pampered a great deal and consequently has developed habits which are an institution and if interfered with mean a long harangue on paper to the physician superintendent'. Although these case file entries identify the doctors as critical of Frederick's privileges and of his character, they also highlight Frederick as having a distinctive personality who rejected interference from the doctors and refused to submit his routine and interests to the hospital's regimen.

The medical superintendents considered religious service as an important part of the hospital's regimen, and it featured on the weekly schedule for Friday afternoons and on Sunday mornings. Outside of these scheduled times, a handful of patients spent their

leisure time in religious devotion. These patients did not express psychopathologies that contained religious content, and as long as their devout behaviour did not interfere with their work commitments and did not pose problems to the running of the hospital, the patients' religiosity was acceptable for the doctors. For example, Henry was noted to be 'saturated with religion' but as he remained 'quiet, amenable' and 'generally pleasant', his 'ultra-pious' behaviour was not regarded to be a symptomology of mental illness (PR 10360/189). Once a patient's devotion influenced their work duties and required the hospital to accommodate their needs, their behaviour was linked to a symptomology of mental illness. Gerhardus in 1920 displeased the doctors by persisting to offer 'lengthy graces in hymn and psalm after each meal'. In 1921, following an interview with Gerhardus, a doctor noted that:

> He spends several hours daily singing his psalms aloud and reading his Bible or books on religious topics. In conversation he is apathetic, retarded and drawling. He shows a distinct poverty of thought and his memory is defective … He never works, but spends the day in religious devotion. (PR 10360/90 n.d.)

Here Gerhardus was seen to exhibit 'epileptic religiosity in a marked degree', but it is imperative to signal that this was a diagnosis based on one doctor's assessment, as well as a set of behaviours and conditions presented by Gerhardus at one point in time. At many other points in time, Gerhardus's religiosity was an expression of his personhood. In his long institutionalisation of over four decades, a recurrent feature was that Gerhardus sang to himself and sang graces before meals. He pleaded with the doctors to 'sing his psalms … and read his Bible', as this made his life meaningful. Moreover, these aspects allowed him to survive his institutionalisation, as he declared that he was content to remain in the hospital, 'as long as he has his books on religion and is allowed to attend services and sing his grace allowed for 10 minutes every day'.

Foreign tongue

During the late nineteenth and early 1900s, the hospital received a fair share of patients who were migrants and immigrants (Du Plessis 2020). In June 1898, after spending a night wandering about and speaking incoherently, Benatoni was detained in a gaol and placed under medical examination to ascertain if he was insane. The certifying doctors found him to be insane, as he talked 'irrationally in half a dozen different languages' (PR 10360/35). He was admitted to Valkenberg Asylum on 8 June 1898 and was transferred to the hospital on 15 December 1900. During his institutionalisation at Valkenberg, very little biographical information was obtained, and thus the hospital's case files are a blank pertaining to his history. In the first report of his condition at the hospital, a doctor stated that he 'is a Greek who speaks a patois it is impossible to decipher'. The transfer of Benatoni from Valkenberg to the hospital on 15 December 1900 included several other patients, one of whom was Marks. While under incarceration for a charge of theft, Marks was certified insane and sent to Valkenberg. Like Benatoni, his case files are a near-complete blank for his biographical details, and the doctors bemoaned that he was 'Greek whose knowledge of English is strictly limited' (PR 10360/37). Four days after the admission of Benatoni and Marks to the hospital, Juan was admitted. In October 1900, Juan was shipped out from Buenos Aires to Port Elizabeth, as a cattleman. Shortly after

his arrival in South Africa, his general behaviour became so strange that he was detained with a goal for medical examination. The doctors found him to be insane, and they observed that he 'cannot carry on a connected conversation' (PR 10360/38). At the hospital, the doctors declared that he 'speaks in an unknown tongue'. Eduardo was found half-clad wandering about a town and was detained in a gaol for medical examination. He was diagnosed as insane and was admitted to the hospital in July 1904 with the doctors declaring that he 'is unable to speak a word of English' (PR 10360/68). In his possession were documents showing that he had suffered two previous attacks of acute mania that were treated in Italy – one of which was at the Provincial Psychiatric Hospital of Como.

Speaking in 'unknown tongues' with little or no command of English, conversing with these men was 'impossible' (PR 10360/35) for the doctors. Yet, it appears that the doctors were not very interested in identifying the language that these men spoke. For example, in 1908, the doctors noted that Benatoni was 'Always talking to himself – apparently in Italian', but by 1921, they stated that with him being a Greek, 'nothing can be understood' from him. In Marks's case, a doctor remarked that, as he was unable to understand what Marks says, 'nothing by way of information about delusions can be got out of this man'. The doctors did not employ translators to aid them in interviewing and questioning the men and thus the onus was on the men to understand and make themselves heard. Eduardo was blamed for never attempting 'to make himself understood', and in Juan's case, the doctors tendered that although 'it is possible that he understands no other language but his own', they still complained, 'he makes no attempt to understand anything said to him'.

In the absence of the patients' speech, the doctors relied on observing their behaviour and appearance as indexes of their mental state. By way of example, the doctors remarked that Eduardo 'looks very depressed'. As much as the men's behaviour was studied for signs of seemingly, apparent or probable mental instability, it was also their expressions of good behaviour that the doctors held as indicators of mental stability. In these instances, good behaviour was anchored to the men conducting themselves as diligent workers and docile patients. Benatoni was saluted by the doctors for having 'woken up', as he conducted himself as a 'good worker and a quiet, well behaved man' while Eduardo was regarded to have 'brightened up considerably', as he was a hard worker. In this formation where patients were praised for their labour, the difficulty in engaging with their feelings, thoughts and emotions, did not aggrieve the doctors, as the men were able to comprehend and 'carry out a simple order' (PR 10360/35), 'obey commands' and 'understand simple directions' (PR 10360/38). In view of the men serving as an unpaid labour force (see also Reaume 2006), some case file entries disregard any mention of a patient's mental condition to focus solely on a patient's work performance, and is evidenced in a doctor declaring that Benatoni was: 'the best worker in the place – cleans infirmary dormitory – polishes everything that will polish and goes at it from morning to night'.

The very little interest the doctors showed in wishing to meaningfully communicate with the men resulted in case files that lack details on not only their mental state but also particulars of their life story. In Marks's case, his age was the only biographical detail captured in his admission documents, and the only point that identified his country of origin was stated in a letter by a magistrate who identified him to be a Greek. In the 30

years of institutionalisation that followed, the doctors stated that Marks remained inaccessible to them, as when they questioned him, he would 'mumble … away in Greek and apparently is not endeavouring to answer the questions'. On Marks's passing, a superintendent wrote to the Greek Consulate to seek their assistance in notifying his next of kin. The Consulate replied that neither was Marks's surname Greek nor was there any record of Greek citizenship. Thus, for three decades, the doctors wrongly assumed Marks was a Greek national and that his Greek tongue was the reason why it was 'impossible to understand anything' he says. We can reason that if meaningful communication with Marks was of earnest interest, the doctors would have sought translators or requested the magistrate to investigate his committal in greater detail. Then again, maybe understanding Marks was of secondary interest to how he was well-behaved and displayed industriousness by 'working well at pumping outside in the yards'.

The entries in the case files for these men identify their status as workers but offer us little in appreciating their personhood. While their case files also lack biographical details, there is a testimony included in the folder for Juan's case. The testimony is written by his foreman, and though the main focus is on detailing Juan's conduct and behaviour as evidence of insanity, there is also a short mention of his identity before the onset of insanity: 'in the Spanish language he is a very well educated man by far the best among the foreign cattleman and is a blacksmith by occupation'. This snippet of information is immensely valuable for offering a glimpse of Juan's life before he was institutionalised. Such a glimpse may aid our appreciation of Juan's personhood, but to fully explore his life story we need to locate archived records of his life from across the globe. This call stems from a recognition that, as the case files only reflect a time in a person's life when they were living with a mental illness (Coleborne 2015, 11), the account will thus only offer a partial and limited period of an individual's life. To gain a more comprehensive picture of a patient's life story, we are tasked to weave the case files together with other archived sources (Sarg, McGeachan, and Philo 2022). To this end, potentially, the archives of Buenos Aires, where Juan shipped from, may have some records of his life.

In Benatoni's case, on his passing in 1937, the superintendent contacted the Italian Consulate to request assistance in tracing his birth records and relatives. The Consulate replied that Benatoni was born in Valperga. In this regard, the municipality of Valperga may hold archived records of his life story. Finally, in Eduardo case, there is the possibility of tracing his case files at the Italian asylums. Here, the intent is not to create a 'linkage' (McCarthy 2015, 65) between the hospital records of the two sites to tell of his 'longer history of mental disturbance' (Coleborne 2015, 41) but to identify biographical details and use them to locate municipal archives that may hold records of his life story. In doing so, the exploration will seek to tell of his transnational life story and thus detail the contours of his life and experiences as stretched across the globe (Coleborne 2015).

Thus far, I have outlined linking the hospital's records with official documents – birth records, marriage certificates, estate documents – housed in state archives, but there is also a possibility to incorporate genealogical research with archival research (Talaga 2024; Wilbraham 2014; Wynter forthcoming). A South African scholar that pursued such an avenue is Wilbraham (2014) who investigated her great-grandfather's case records at the hospital and 'interweaves' them with 'bureaucratic state archival material, … intergenerational family-storytelling and family

photographs' (Wilbraham 2014, 166) to 'produce a biographical account of his life, and the intimate familial arrangements around him' (Wilbraham 2014, 171). While Wilbraham engages with madness in her own family genealogy, Wynter (forthcoming) has expounded on her use of genealogical websites to work with the descendants of asylum patients for 'exchanging information, photos … [and] to flesh out the experiences of individuals'. By following Wynter's lead, in exploring genealogical websites, there is a possibility of locating the descendants of the men's families and engaging with them to enquire if they know further information or stories of the men. The engagement with the family will incorporate, as is evinced in Wilbraham's (2014, 170) study, the 'family stories' and 'memory traces' of the men, but it will also hold benefit to the family for sharing with them the men's stories that are contained in the hospital's files for potential inclusion in the family's storytelling of their descendants' lives. It is worth noting that in working with genealogical sources, we may be facilitating a form of historical justice (Neumann 2014). The hospital failed to locate the men's next of kin and thus they were eventually entombed with unknown tongues, unidentified families and untold life stories. By locating the kin of the men, the research will restore the memory of the men to have a family and a transnational life story.

Family connections

In the sample of the case files, there are only two patients who received the absence of leave from the hospital to visit their families. The low occurrence of leave from the hospital for the patients under investigation should not be attributed to their families having forgotten them but rather a consequence of colonisation 'where people moved around within and between far flung colonial sites' (Wilbraham 2014, 181). Owing to such great distances between the patients and their families, letter-writing provides a useful channel to maintain contact and connection with their institutionalised relatives (Coleborne 2006, 2010). In the ensuing discussion, I investigate letter-writing between families and the superintendents as a means to stay bonded to a relative who, owing to several factors including their age, infirmity and mental condition, was unable to write. The letter-writing between families and the superintendents can be grouped into two main categories, namely, correspondence concerned with sending gifts to the patients and correspondence regarding the imminent passing of a patient.

In terms of gift correspondence, a focal point in the letters between a superintendent and the mother of Charles was her request to provide Charles with an iced cake for his birthday (PR 10360/71). The mother lived in Kimberley – some 650 km from the hospital – and for several years sent money to the superintendent to purchase Charles a birthday cake. The gift-giving of Charles's mother can be regarded as an act to celebrate his life and also possibly a gesture directed to Charles to remind him that his family remains connected to him. In other cases, gift giving pertained to acts of honouring and respecting family ties. Following her father's death, Elfriede became Franz's primary contact. Although she was his niece, she had never met him before. Initially, what can be considered as an act of charity, as Franz was wearing hospital-issued clothing; she sent Franz a parcel of her deceased father's clothes. But, in the packages thereafter, the contents were somewhat luxurious in being meant solely for pleasurable indulgences.

For example, in 1941, Elfriede posted him 'a few sweets and a pipe and some tobacco' (PR 10360/29). In 1947, Franz sustained a serious injury and a superintendent proceeded to inform Elfriede of the incident. She thanked the superintendent for informing her and enquired if 'there is any little comfort he is able to enjoy . . . and I will do my best for him'. The superintendent replied that he 'would be able to enjoy eatables'. Elfriede heeded the superintendent's recommendations and sent Franz a parcel containing:

> Two packets of biscuits, three slabs of chocolate (different sizes) and some other sweets . . . I shall be very grateful if you will kindly see that these are given out . . . in regular amounts. I shall endeavour to send a parcel now and then, and hope they will give him a little pleasure.

In the correspondence regarding the imminent passing of a patient, the superintendents would write to request the family to visit the hospital to pay their respects to their relatives. By way of example, when Edward's long suffering from renal and cardiac disease eventually led to him collapsing one night, a superintendent telegrammed his family to inform him that 'it is feared he will not recover' and thus 'it is considered advisable that you call to see him today' (PR 10360/15). For families that lived in the distant reaches of the country or even outside of South Africa, they were neither able to visit their dying relatives nor attend the funerals, but they did provide instructions to the superintendents for making the funeral arrangements. On receiving a telegram notifying the family of Charles's death, his sister wrote to a superintendent to ask if her requests for him to buried 'decent' where carried out. She added that she would cover the expenses for a small stone cross to be placed over his grave and for the grave to be marked off with bricks. The brother of Henry resided in Maseru, Lesotho, and telegrammed instructions to a superintendent for Henry's funeral arrangements – these included requiring a reverent to officiate the ceremony (PR 10360/189). Residing in Rhodesia, Norman's brother requested a superintendent to arrange a private funeral for Norman. Shortly after the funeral, he wrote to a superintendent to put him in communication with a monumental mason, as he was 'anxious to put up a headstone' to Norman's memory (PR 10360/9). Although these families were not able to pay their final respects to the patients at their bedside or at their funeral, their letters containing instructions for the burial and funeral arrangements can be considered an act of honouring their relatives, as the absence of a family's instructions and financial commitments to pay resulted in the deceased receiving a pauper burial. Moreover, the families' interest in erecting tombstones and grave markers may be regarded as a desire to 'permanently commemorate the deceased' (Farrow 2024, 35) as an individual, as well as affirmed their rightful belonging to the family's name.

In the letters exchanged between the superintendents and families, each party's communication followed a dominant narrative pattern (see also Coleborne 2006). In terms of the superintendents' correspondence, in replies to a family's request for information on the state of their relative, their feedback focused on the clinical condition of a patient, namely the symptoms of mental and physical illness. For example, a superintendent informed Joseph's sister that 'unfortunately there is no chance of him getting better . . . Mentally he is very delusional and also talks a lot of nonsense'. In her correspondence to a superintendent, the mother of Charles would often enquire about her son's state, to which he replied, 'Mentally he remains the same. Is keeping quiet. His body health is well, inclined to be stout'.

Once Elfriede became Franz's primary contact, she wished to acquaint herself with Franz's life story and condition, and enquired from the superintendent what was Franz's

> mental condition. Is he physically strong, are there times when he remembers things, and what is his age now? . . . Is there anything Franz is able to enjoy, and is he conscious of any pain now that he is in hospital? An answer to my enquiry would be greatly appreciated, with anything else you would like to tell me. Is there any little comfort he is able to enjoy, please let me know, and I will do my best for him.

The superintendent replied in stating that Franz was admitted to the hospital on:

> 25 May 1900 and his date of birth 25 Dec 1869. Mentally he has for many years been in a demented state and it is not possible to converse with him. He is physically infirm and has for long required much nursing care. He is unable to state what he would like sent to him, but should you wish to do so, he would be able to enjoy eatables such as biscuits, as he takes his food moderately well.

Here, we clearly see that the superintendent's reply offers a portrait of Franz's patient-hood: identifying him by his mental illness, incapacities and physical infirmity. While the superintendent indicated, 'it is not possible to converse' with Franz owing to his 'demented state', Elfriede's request for 'anything else you would like to tell me' could have been answered if the superintendent reviewed the case files to ascertain details of Franz's committal and family history. Yet, these details were likely deemed of inconsequential value to how the superintendent favoured reporting on Franz in terms of his patient-hood. Even in answering Elfriede's request for what Franz is 'able to enjoy', the superintendent focuses on Franz's patient-hood by stating that he ingests his food 'moderately well'. Thus, the superintendent's reply attributes Franz's enjoyment not to aspects of his personhood – having the capacity for expressing delight and pleasure – but to his patient-hood, as he could ingest his food with ease. Significantly, this was not the first instance in which the superintendents negated Franz's capacity for expressing delight and pleasure. In 1941, when Elfriede posted Franz 'a few sweets and a pipe and some tobacco', she requested the superintendent to let her know 'whether these small articles were appreciated by the patient', he replied that Franz 'did not show much interest or appreciation'.

In the families' letters to the superintendents, they often expressed grief and sorrow. On receiving correspondence from the superintendent, that Joseph was suffering from cancer of the liver that had spread to the other organs of the abdomen, his sister expressed grief that 'after so many sad years of life that he should meet with this full disease and I suppose always in pain'. She also 'fretted' that she could not help him, as she was 68 years old, a widow and unable to afford the long journey to visit him and thus begged for 'those around him to be kind in his last hours as I would like but unable to do so'. Joseph's sister was saddened and distraught to think that 'he is always in pain' while Franz's sister was troubled by her brother's 'sad state' and Elfriede felt 'so very sorry for the poor soul'. While grief and sorrow constitute a narrative pattern in the letters of the family to the superintendent, I contend that they do not stem from guilt from committing them to the hospital and I support this contention in a twofold manner. First, in the families' correspondence, it is evident that their grief and sorrow are an 'emotional performance' (Coleborne 2006, 437) connected to expressions of Christian piety. For

example, in the letter written by Joseph's sister, her expressions of sorrow are followed by prayers for 'God in mercy' to alleviate Joseph's suffering and to bless the superintendent 'for any kindness to my sad brother'. Second, in the cases under investigation, the families only sought the committal of their relatives when violence became a growing concern. Charles (age 34) was first admitted to hospital in November 1902 suffering from intemperance and grief following the death of his brother. While at the hospital, for much of 1904 he was 'very impulsive and violent'. In spite of his state, in October 1904, his family requested the superintendent to discharge him into their care. His father hoped 'that a life on the farm would do him good' but once home he became very violent and attempted to strangle his brother. Thus, in the case of Charles, we see that it was the unsuitability and incapacity of the family to manage outbursts of violence that led to the decision to seek his re-committal to the hospital.

Overall, in the families' correspondence, we witness them holding their relatives in personhood – as individuals with 'feelings, thoughts, desires, and intentions' (Nelson 2002, 34). In their gift giving, a mother commemorated and celebrated Charles's birthday, and a niece gifted an uncle she never met with indulgences that aimed to give him 'pleasure'. These families continued to send gifts to their relatives in spite of the superintendents' dehumanised representation of the patients to be incapable of expressing interest or appreciation. Stated differently, despite the superintendents' undignified representations of the patients, the families continued to recognise and respect the men as individuals and as members of their kin. Moreover, in their instructions for burials and funerals, families commemorated the deceased and in erecting stone markers and memorials, attested to the 'lasting nature of social and affective bonds' (Farrow 2024, 35) of the family to the deceased.

Elfriede's interest in enquiring about Franz's life story can be regarded as an interest recognising him as an individual whose life story matters to 'intergenerational family-storytelling' (Wilbraham 2014, 166). In this regard, rather than opting to sever connections, with Franz following the passing of her father, and thereby shrouding Franz's existence from her family history, maybe she wished to include Franz's life in her family tree and by extension, add what stories he remembered to the 'family narratives' (169). Elfriede's enquiries can also be read as an interest in learning more about his 'acts, experiences, characteristics, roles, relationships, and commitments' (Nelson 2002, 30) to aid the telling of stories that testify to his personhood. In this way, although Franz was unable to offer a first-hand account of his life, Elfriede's search for more information on his life may have been motivated by seeking to preserve his personal identity and his stories when he was no longer able to do it for himself (30). For this reason, every detail or titbit of information would have been prized and would have contributed a 'richer' identity to who Franz was.

As already indicated, the superintendents did not provide Elfriede with details on Franz's life and only narrated aspects of his patient-hood. In a gesture to respond to Elfriede's request and to honour Franz's personhood, I provide the following details of his committal. Franz was a farmer, and at the age of 25 had suffered from a severe fall from a horse that left him stunned for hours. His attack of insanity commenced when he was 27. He was cared for at home for 2 years before he was committed to the hospital, as his parents, brothers and sisters could not manage to watch him night and day. If not under their watch, he would enter the homes of strangers, would not take food for

extended periods of time and even go missing for a few days. At the age of 29, Franz was admitted to the hospital with his family paying a maintenance of £6 per month. This exploration of Franz's case files offers very little details of his voice and agency but does highlight how his life story shows evidence of the family supporting his journey with mental illness by offering him home-based care for 2 years before admitting him to the hospital as a paying patient. Potentially, their support can be regarded as a testimony that they acknowledged Franz's personhood. Franz's case file thus neither offers a biography of his life nor presents a romanticised history of his life with mental illness. Nevertheless, by exploring the case files, we can construct an 'empathetic foundation' (Reaume 2018, 30) for the portrait of Franz as an individual who was loved by his family.

Conclusion

In an afterword to a collection examining the use of case files for social history, Dubinsky (1998, 359) concludes that the contributors were all 'concerned with the process of telling stories about dead people who, in a certain sense, never really "lived", at least as far as the historical record is concerned'. In a similar vein, the published historical record for the Fort England Hospital represented the chronic patients as 'unlived' lives: the texts represented the chronic patients as anonymised cases of disease pathology who were mentally 'dead' (Greenlees 1907, 22) and thus incapable of living a meaningful life. The article sought to redress the representation of the patients by telling stories of their experiences and agency, how their kin upheld them in personhood, and how their families engaged with remembrance. In doing so, the article has restored a dignified memory of the men to the history and heritage of the hospital. For Rodéhn (2022, 1002) 'scholars construct heritage when writing' about psychiatric institutions and spaces, as in the process of 'telling untold stories', the 'texts are performative' (Rodéhn 2022, 1007) – they produce discourses of heritage. Building on Rodéhn's thesis, the findings of the article have not only added the stories of the patients to the hospital's heritage but also moved beyond heritage discourses of regret (Rodéhn 2022, 1013) to explore the discourses of mad studies. In an erudite discussion on the ethics of researching psychiatric case files, Reaume (2018, 35–36), calls upon scholars in mad studies to consider ways in which they can make their research on patient histories 'more widely available in the hope that family members and communities to which they belonged will be able to reconnect and honour disabled and mad people's contributions to our understanding of the past'. The article has laid the groundwork for embarking upon exploring genealogical websites, and it is my hope that I will be able to trace some of the patients' families and thereby offer a symbolic repatriation of the deceased to be included and remembered in their families' tree and storytelling.

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Notes on contributor

Rory du Plessis is an Associate Professor at the School of the Arts, University of Pretoria. He has pioneered the investigation of photographic records from South African psychiatric facilities as a resource to humanise the subjects who were institutionalised in the late nineteenth and early twentieth centuries. He is the author of *Pathways of Patients at the Grahamstown Lunatic Asylum, 1890 to 1907* (PULP 2020), *I See You: A Photo Album of People with Intellectual Disability* (ESI Press 2023) and *Automaton (tik): In Remembrance of the Patients of the Fort England Psychiatric Hospital* (ESI Press 2025).

ORCID

Rory du Plessis http://orcid.org/0000-0001-8907-9891

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