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## Accounting for Madness:

### The “Real Casa dei Matti” of Palermo 1824-1860

*“To make a lunatic asylum of it, similar to that founded by the Count of Pisani at Palermo.*

*Do you know about that institution?”*

*“I have heard of it.”*

*“It is a magnificent charity.”*

Alexandre Dumas, *The Count of Monte Cristo*, chapter 69.

*“All punishments were avoided – that even confinement was seldom resorted to – that the patients, while secretly watched, were left much apparent liberty, and that most of them were permitted to roam about the house and grounds in the ordinary apparel of persons in right mind”.*

Edgar Allan Poe, *The system of Doctor Tarr and Professor Fether*.

#### Introduction

Critical accounting scholars who have developed sophisticated and influential understandings of accounting as a social, transformative practice have given particular prominence to the work of Michel Foucault in the study of a variety of organisations and institutions such as hospitals and the church (Miller and O’Leary, 1987; Miller and Rose, 1990; Stewart, 1992; Armstrong, 1994; Hoskin, 1994; Neimark, 1994; Tinker, 2005; Sargiacomo, 2009; Macintosh, 2009; McKinlay and Pezet, 2010; Mennicken and Miller, 2012). Although these studies have been heavily reliant upon insights from Foucault, until the present study this influence has not extended to the subject which provided the original impetus for his work, the insane asylum.

From his earliest writings a number of Foucault’s works, but most especially *Madness and Civilization: A History of Insanity in the Age of Reason*, were concerned with the history of mental illness and lunatic asylums such as Salpêtrière, Bîcetre and the Retrait in France (Foucault, 1967; 2004, 2006a, 2006b). To address this gap, the present study will examine the role of accounting in the life of the “*Real Casa dei Matti*”, the Royal House of Madness, hereafter the RCM, a renowned lunatic asylum founded in 1824 at the dawn of modern psychiatry which was located in the city of Palermo, in Sicily. By applying a Foucauldian historical analysis to the RCM this study allows a better understanding of the role of accounting as a means of exercising power to control silent and disadvantaged groups (Foucault, 2003; Walker, 2004, 2008; Holden *et al.*, 2009; Smarck and Bowrey, 2010; Sargiacomo *et al.*, 2012; Servalli, 2013). It also provides the

opportunity to broaden understanding of the importance of accounting to charitable institutions at a time when they were growing into the modern equivalent of hospitals.

The first director of the RCM was Barone Pisani, a Palermo-born nobleman who was widely known and popular at the time. Pisani is mostly remembered for introducing “moral therapy”, an emerging treatment programme for the insane promoted by several doctors in Europe, most notably Philippe Pinel and Jean Etienne Dominique Esquirol in France and William Tuke in England. Moral therapy is especially remembered for the way in which it physically liberated the insane by removing them from the company of criminals and paupers (Merquior, 1985, p. 24). From the mid-15<sup>th</sup> century both the poor and the insane were housed together in medieval hospitals which were more like prisons (Finzsch and Jutte, 2003). The danger of the lunatic was compared to the danger of the poor who were regarded as socially destabilising (Foucault, 1967). Until the development of moral therapy, treatment of mental illness in asylums at the close of the 18<sup>th</sup> century continued to rely upon physical restraint in the form of chains and segregation of the mentally ill with other social outcasts who were forced to live in poor conditions (Jones, 1972, p. 7, 16; Smark and Bowrey, 2010, p. 170; Foucault, 1967; Porter, 1992; Bové, 1992; Woods and Carlson, 1961; Harris, 2003; Huertas, 2008). This was the ‘great confinement’ that is crucial to Foucault’s historiography of mental illness and to his views on the interplay between “new” institutions and power (Porter, 1992).

The success of the RCM was heavily dependent on the collection, classification, processing and displaying of a large amount of financial and non-financial information about its patients’ mental health and their care. This information fulfilled a crucial role in the management of the mentally ill by enabling categories of illness and treatments to be identified. These then provided the means to group inmates according to these categories and to be able to manage each group appropriately by providing, as required by moral therapy, the living conditions which were to be the means not only to control but to restore patients to society. The aim was to provide the environment which would encourage patients to internalize expectations for a healthy life and, thereby, to normalize their behaviour.

The information collected was also critical to the survival of the RCM by providing the means for the RCM to account for its operations to the regional political authorities and to the general public, the more affluent upon whom the RCM relied for generous endowments and bequests. To fulfil these expectations, the RCM developed accounting practices to plan capital investments, to measure, record and manage its costs and to negotiate its yearly budgets to raise funds from public organisations and private benefactors, which were often reluctant to fund the institution. Accounting information provided the means to enlist and maintain the financial support of wealthy influential individuals by showing them both the financial needs of the asylum and the effective manner in which the resources provided were used to treat and restore the mentally ill to society as productive citizens. Thus, management of the RCM recognised an intimate, dependent relationship between financial performance and the ability to treat and, especially, cure mental illness.

This study of the RCM has been conducted using a variety of sources, both primary and secondary. The most important primary sources used are the documents from the State Archives of Palermo (MBAC, 2010), most especially the Court of Audit section. The other important source of information has been the patients' clinical records from the RCM (18 boxes) held by the Local Health Unit of Palermo which covers the middle decades of the 19<sup>th</sup> century. Amongst the latter are documents which record the visits of well-known contemporaries to the RCM which at the time was recognised internationally as outstanding in its practices and the results achieved. The records of the State Archives of Palermo contain documents which provide details about internal rules, management deliberations, registers, reports, lists of lunatics admitted to the RCM, letters and communications which highlight the nature of the relationships between RCM management and local and central government. The State Archives provide details of the first time in Europe when patients were grouped according to a scientific taxonomy as required by moral therapy. Reference is also made to the ideas of Pinel, Esquirol and others, which so decisively shaped the experience of the RCM.

The remainder of the paper firstly provides an overview of the theoretical framework of the research, which draws upon insights from Foucault, followed by a description of the political and social milieus in which the RCM operated. The organisational, operational and clinical profiles of the RCM are then discussed. The final main section of the paper reviews the complex, multiplicity of roles which accounting served at the RCM. The conclusion summarises the findings of the paper and suggests avenues of possible future research with other similar institutions both in Italy and elsewhere.

## **Method**

Foucault's concepts of disciplinary power and governmentality have provided a rich source of insights for accounting researchers and for scholars across many other disciplines. Foucault (1967, pp. 79-112) argued that from the 18<sup>th</sup> century power no longer acted overwhelmingly in a violent manner to repress behaviour which was condemned as unacceptable to those in power but instead intervened subtly and even unseen through sets of practices to influence people's actions to force them to unconsciously co-operate in their subjection to power (Hoskin and Macve, 1986). They became their own disciplinarian. This process was strengthened by the emergence of human sciences, most especially medicine and psychology (Foucault, 1967, p. 244), which used their authority and influence to determine expected, acceptable norms of behaviour for their human targets. This normalizing judgement sought to correct behaviour which contradicted that which was approved and sanctioned, thereby creating a relationship between the subject and the practitioners of the new sciences characterized by an asymmetry of power, Foucault's "power-knowledge" (Armstrong, 1994), whereby those who controlled the understanding of power were provided with the means to control people.

The cornerstone of these disciplinary regimes was continuous hierarchical observation, where the observer and the means used to exercise their power may not have been obvious to the person observed. Instead, it relied upon the examination in which the mechanisms of disciplinary power are combined, allowing each person to become a documented case (Foucault, 1967, p. 209). Numerous studies have established how

accounting becomes a disciplinary power, an integral part of a complex web of power-knowledge structures (Stewart, 1992) which helps to make people knowable and calculable, transforming them into “docile bodies” (Hoskin and Macve, 1986; Miller and O’Leary, 1987). Accounting cannot be seen simply as a neutral tool, the emphasis of which is economic rationality, but instead is profoundly implicated in power relations produced in social life, most especially at the level of the State (Miller and O’Leary, 1987; Napier, 2006). The present study provides an exceptional means to expose the contributions of accounting to disciplinary power at a time when Foucault believes that the form of the modern State was emerging in institutions such as prisons.

Foucault’s concept of governmentality has also proved to be a rich source of insights for scholars. He traces this technology of power to the 18<sup>th</sup> century when governments had to face large increases in population and related expenditures. This caused a shift from the traditional form of sovereign power where authority was based upon long established custom, social class and patronage to a regime ruled by techniques of governing (Foucault, 1991, p. 101). The main constituent of the State was no longer its territory but its population which became the object of government. This new priority has required that those who govern have greater knowledge of those whom they seek to dominate and rule. Population is not simply the sum of individuals but a complex phenomenon with a life of its own which has to be mastered according to specific knowledge and through the use of apparatuses of security (Golder, 2007, p. 164; Foucault, 2007, pp. 61-62). Thus, governmentality is

the ensemble formed by the institutions, procedures, analyses and reflections, the calculations and tactics that allow the exercise of this very specific albeit complex form of power, which has as its target the population, as its principal form of knowledge political economy, and as its essential technical means apparatuses of security (Foucault, 1991, p. 102).

The functioning of the technology of power requires, according to Foucault, a broad set of techniques which can be grouped into two typologies (McKinlay and Pezet, 2010, p. 487): those that individualise by targeting the body, which he refers to as disciplinary power, and those which regulate behaviours by targeting the whole population. To achieve effective power, the State has to intervene on *omnes et singulatim* (one and all), directing the behaviour of every individual and of the whole population at the same time. Identifying the population for Foucault was the means by which individuals could be constructed as an object which would then be governable (Foucault, 2001). Thus, the State since the 17<sup>th</sup> century has been both individualizing and totalizing (Foucault, 2003, p. 145). It has sought to intervene in the attitudes and behaviour of every individual to induce them to behave in a way which was consistent with the aims of the State and, at the same time, acted on each individual as part of the population as a whole which the State sought to master according to the rules of political economy. The basic principle of modern politics, which characterizes the modern, “governmentalized” State, is this constant correlation between individualization and totalization, action ‘on all and each’ (Foucault, 1991, p. 103; Marzocca, 2001, p. 15). This requires access to a diverse array of quantitative information, which could be financial or non-financial, to target and expose the individual to allow control of the total population.

## Normalising Judgements and Statistics

The importance of information or, in Foucauldian terms, ‘statistics’ as a technology at the service of power has been a significant feature of Foucault’s philosophy, even if he did not systematically explore it in technical terms or its applications. In the context of the asylum, statistics play crucial medical, management and social roles by giving measurability and visibility to the elusive, qualitative, subjective nature of mental illness. “A disease was to be accounted for that could attack the head as well as the legs” (Foucault, 1967, p. 145). According to Foucault, statistics are essential for producing average indicators to build a prevailing, representative picture of the observed universe to allow it to be given visibility so that deviations from this social norm can be measured, controlled and managed. Foucault (2004, p. 159) notes how, mostly in the context of mental health,

deviation from the norm of conduct and the degree to which this deviation is automatic are the two variables that enable conduct to be inscribed either on the register of mental health or on the register of mental illness. Broadly speaking, conduct is healthy when there is minimal deviation and automatism, that is to say, when it is conventional and voluntary. ... (P)sychiatry can now take into its field of analysis an enormous mass of data, facts, and behaviours that it can describe and whose symptomatic value it can question in terms of deviations from the norm and position on the voluntary-involuntary axis.

Although Foucault most often discussed normalization as a technique of power, its epistemic implications clearly emerged. Normalizing judgment produced

a whole range of degrees of normality indicating membership of a homogeneous social body but also played a part in classification, hierarchization and the distribution of rank. In a sense, the power of normalization imposes homogeneity; but it individualizes by making it possible to measure gaps, to determine levels, to fix specialities and to render the differences useful by fitting them one to another (Foucault, 1977, p. 184).

Specification of what constitutes acceptable behaviour, the process of normalisation, which was the basis of the approach taken by moral therapy, required individuals to be grouped to allow treatment to be more precisely, and thus effectively, targeted to the particular forms of mental illness identified (Armstrong, 1994, p. 62). This required the categorising of the mentally ill according to their symptoms, thereby providing the conditions which would allow treatment to be targeted to categories, or ‘populations’, of individuals. Thus, the primary focus of moral therapy was categories or groups rather than specific individuals. Creating the conditions which were believed to be conducive to mental well-being would allow individual patients to become instruments in their own redemption by inducing them to behave in a manner which was more consistent with their fellow patients as they approached an implanted norm.<sup>1</sup> According to Foucault (1978, pp. 145-6), statistics gave rise to

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<sup>1</sup> The main protocols adopted in moral therapy in Retreat, under Tuke’s leadership (as described in Tuke, 1813, pp. 131-187), and Bicêtre, according to the guidelines proposed by Pinel in his most important book (Pinel, 1806, pp. 48-104) are noted in Appendix 1.

infinitesimal surveillances, permanent controls, extremely meticulous orderings of space, indeterminate medical or psychological examinations, to an entire micro-power concerned with the body. But it gave rise as well to comprehensive measures ... and interventions aimed at the entire social body or at groups taken as a whole.

The ability of statistics to be the basis of normalizing judgements allowed statistics to become a powerful controlling instrument in the asylum, a means to 'watch over' in Foucault's semantics, to detect multiple aspects in the life of each individual as representing a category of characteristics and by aggregating the data to govern social systems. To measure and define a behavioural standard which was to be adhered to, and by which to assess deviance, data needed to be collected continuously to "ensure that everything that happens, everything the individual does and says, is graded and recorded, and then to transmit this information from below up through the hierarchical levels" (Foucault, 2006a, pp. 48-49). In the case of medical statistics these were intended to make the mental and physical condition of patients measurable, identifiable and potentially treatable. Every possible relevant detail about patients was meant to be found and recorded, for measuring is inseparable from classifying which was the core business of medical science and most especially psychiatry (Foucault, 2003, p. 35). Finding and processing a multitude of details about patients and their conditions were the key technologies behind the success of medicine in the 19<sup>th</sup> century when the

birth of pathological anatomy and, at the same time, the appearance of a statistical medicine, of a medicine of large numbers—both the ascription of precise causality by the projection of the illness on a dead body and the possibility of inspecting a set of populations—provide the two major epistemological tools of nineteenth century medicine (Foucault, 2006a, p. 248).

Details about patients and their conditions make evidence definable, thereby allowing statistical recurrence to be replicable and comparable. Most especially, statistical findings allow deviations from a previously determined norm to be used to understand the character of the universe and, therefore, to govern a community, most especially from a physical and biological point of view. It is here that the concept of the microphysics of bio-power becomes important (Foucault, 2007, p. 23).

The techniques and technologies of power which were used by the RCM can be identified with Foucault's typologies which individualise by targeting the body (disciplinary power) and those which regulate behaviour by targeting the whole population, the apparatuses of totalisation (McKinlay and Pezet, 2010, p. 487). These are closely associated with Foucault's conception of biopower whereby the body is targeted as an organism and part of broader biological processes (Foucault, 2003, pp. 242-243; Sorrentino, 2008, p. 100). Foucault exposed the way in which bio-power intervened in the biological substratum of society, that is, in reproduction, sanitation, nutrition, health, and family life, in a way that was historically unprecedented. In addition to the emergence of the human sciences, for example criminology, social work, and modern psychiatry, many new means of social monitoring such as diagnostic categorization, case dossiers, and statistical analysis were devised to guarantee the

normalized homogeneous population required by the interests of the bourgeoisie (Whitebook, 1994, p. 332). Foucault's view of the descriptive or prescriptive status of the norm is especially important for understanding his claims about the modern conjunction of power and knowledge (Foucault, 1978).

The application of statistics to the specific area of mental illness is an outcome of the more general medical uses. Of particular significance for the present study, in his *Psychiatric Power: Lectures at the Collège de France, 1973-74* Foucault focuses on the role of statistics in the philosophy and work of Esquirol and Pinel. According to Foucault, Pinel introduces a new dimension in the management of lunatic asylums, not least because he was one of the first supporters of the importance of data collection. Foucault (2006a, p. 197, note 30) refers to the way in which "Pinel recommends 'keeping exact journals of the progress and diverse forms taken by the insanity throughout its course, from its onset to its end'". Foucault sees Pinel's ideas and work as the development of a new control strategy, the creation of an objectivizing discourse, pejoratively qualified as "monologue by reason about madness," which remains alien to the deeper meaning given to insanity (Beaulieu and Fillion, 2008). Accordingly, rather than recognise Tuke and Pinel as innovative medical practitioners, Foucault attributed to them the "invention" of mental illness as a social construction (Midelfort, 1995, p. 143).

Foucault denounced "the Myth" of Pinel and Tuke and of the other physicians such as Esquirol who adopted moral therapy. He considered Pinel and Tuke to be false humanists and agents of power whose view of humanity entailed the values of bourgeois society (Beaulieu and Fillion, 2008, p. 85). Contrary to hagiographies of Pinel, Tuke and Esquirol, Foucault rejected Pinel's reforms as a form of humanism when his entire practice was still permeated by a form of violence; moral violence (Foucault, 2006a, p. 14). The mad may have been freed from their physical chains (Harris, 2003) but they were "imprisoned in a moral world", a "gigantic moral imprisonment" (Gutting, 2005, p. 45) where the shackles on inmates were now moral imperatives; the values and beliefs of those who controlled the understandings of what was accepted were to constrain, regulate and ultimately normalize behaviour. The new human science of psychiatry in particular was to be a means of interpreting the expectations of society. The aims of the RCM epitomised these expectations.

### **The Foundation of the RCM**

In 1805, after Napoleon's invasion of the Kingdom of Naples, King Ferdinand and his court fled to Palermo under the protection of the British Navy (Cingari, 1976). After the defeat of Napoleon, the House of Bourbon was reinstated to the throne of Naples and Sicily and the new State was named the Kingdom of the Two Sicilies. Both events provided a major financial boost to Palermo which underwent a period of rapid development (Di Blasi, 1842). During this time there was also a dramatic renewal of the city's cultural and scientific institutions (Gregorovious, 1914; Duggan, 2007). It was in this cultural hotbed that the University of Palermo was founded in 1805 (Cancila, 2006).

In Palermo the treatment of the insane, who had been associated with the lepers and other inmates of the Church of "*San Giovanni dei Lebbrosi*" (Agnetti-Barbato, 1987),

had been limited to segregation (Bicheno and Fox, 1993). This began to change after the Council of Trent (1545-1563) when madness was starting to lose the almost mystical features by which it had been identified during the Middle Ages and, instead, was regarded as elsewhere in Europe more as an antisocial phenomenon (Szasz, 1976; Giunta, 1991; Roscioni, 2003). Thus, by the mid-15<sup>th</sup> century when the many small hospitals of Palermo had been closed and replaced with a large central facility, the *Ospedale Grande e Nuovo* (The “big new hospital”), the insane were excluded and, instead, were admitted to poor people’s houses along with the other social outcasts (Carta, 1969; Bonaffini, 1980). The situation dramatically changed in the 18<sup>th</sup> century when medical science made noticeable progress, with mental illness beginning to be more accurately defined and no longer identified with poverty. Then the need was felt for society to address the problems of social inclusion more selectively (Valenti, 1985; Fuller Torrey and Miller, 2001).

In the late 18<sup>th</sup> century the treatment of the insane in Palermo started to attract the interest of intellectuals and benefactors, who regarded the miserable living conditions of the insane as humiliating for humankind. In 1802, the King ruled that all mentally ill people were to be moved to the new *Ospizio di Santa Teresa*, a disused convent converted into an asylum where they were to be given greater compassion and care (Agnetti and Barbato, 1987). A decade later, in 1813, also in the Kingdom of the Two Sicilies, a lunatic asylum was opened in Aversa, near Naples (Cascella and La Pegna, 1913; Simoneschi, 1835). Subsequently, there was an increasing tendency to establish mental asylums as specialist facilities for the admission and treatment of the insane (Bewley, 2008; Boschma, 2003; Coleborn and Mackinnon, 2003; Goodheart, 2003; Mellling and Forsythe, 2006; Smith, 2007).

Very quickly the treatments used in the Aversa asylum became well known among Europe’s scientific communities and attracted the attention of specialist doctors in many countries. This encouraged Francis, Prince Regent of Sicily, to establish in 1816 a new lunatic asylum in Palermo modelled on that operating in Aversa (Valentin, 1822; Gualandi, 1823; ASP, 1816). However, this proposal was opposed by the City Senate and the *Ospedale Grande e Nuovo* of Palermo who were not prepared to tolerate a health care facility under the patronage of the Crown and outside the Senate’s control. Accordingly, the senior government official, the *Luogotenente Generale*, appointed a committee to investigate the problem and find a solution (Pampanini, 1985). However, not until 1824 was the then new *Luogotenente Generale*, Marchese delle Favare, able to persuade the new King, Francis I, to open a facility for the treatment of lunatics, the *Ospizio dei Matti*. Thus, on 10<sup>th</sup> August 1824, the *Luogotenente Generale* appointed Barone Pietro Pisani *Deputato* for both the *Ospizio di Santa Teresa* and the *Ospizio dei Matti* (ASP, 1824), later renamed “Real Casa dei Matti” under a decree of King Francis I in 1827 (Agnetti and Barbato, 1987).

The Pisani family in the 16<sup>th</sup> century had moved from Venice to Sicily where it held the office of tax collector for North Eastern Sicily. Pisani attended classical studies, became passionate about music and archaeology and graduated in law at the University of Catania (Serio, 1839). In 1799, he joined, as a clerk, the *Real Segreteria di Stato* at the Bourbon Court, in Palermo, which was responsible for collecting taxes (Linares, 1837).

In 1812, Pisani lost his lucrative position (Pontieri, 1943). Soon after, Pisani was appointed Head of the Ministry of Interior, reporting to the *Luogotenente Generale per la Sicilia*. It was a very prestigious post with control over civil administration, prisons, the cultural heritage and healthcare (Linares, 1837). When Pisani was appointed *Deputato* of the Ospizio dei Matti di Santa Teresa his position at the Ministry of Interior had exposed him to the conditions under which the mentally ill were detained and as a well-travelled, highly educated official he had become aware of the success of moral therapy in France and England. Upon becoming *Deputato* Pisani was determined to transform the RCM into a lunatic asylum equal to Europe's best by introducing moral therapy.

### **Moral Therapy at the RCM**

Moral therapy drew upon many disciplines, including psychiatry, medicine, sociology and philosophy (Foucault, 2006, p. 9; Peloquin, 1994; Osler, 1997; Charland, 2004; 2015). Moral therapy has been viewed by most historians as the origins of modern psychiatry. Foucault was so convinced of the importance of the work of Tuke and Pinel in the history of psychiatry that he devoted a chapter to their legacy in *Madness and Civilization* (Goldstein, 2002). According to the *Companion Encyclopedia of Medicine*

(t)he Anglo-French 'moral therapy' was intended to be a humane treatment, in contrast to the use of dungeons, chains, and whips, which increasingly were recognized as cruel. Beyond that, it implied an emotional component, later labelled psychological.... Practitioners of the moral therapy contrasted their techniques against the physically-oriented therapeutics of the time, which included bleeding, purging, bodily restraint, and heavy doses of medications (Cooter, 2013, p. 314).

Moral therapy had already been widely accepted at the time the RCM was created (Mora, 1959, 1960). The writings of Pinel (1806) and Esquirol (1819, 1835 and 1845) were available in Italy, even if not immediately translated into Italian. It has been suggested that Pisani had read them in the original language (Agnetti and Barbato, 1987). Moral therapy was based on the "redemption" of the patient and their integration in a different context from "external" society. It relied upon the grouping of patients by attributing to them a lunatic category. De Young (2015, p. 242) has emphasized that moral therapy implied

different types of interactions between asylum physicians and patients ... (It was not at odds with the philosophy of moral therapy to use persuasion, rousing, calming, manipulating, disabusing, distracting, deceiving, frightening and humiliating if any one, or a combination of these strategies, most effectively engaged and directed the patient. It is also important to note that moral therapy ... did not at all preclude the use of restraints, although its practitioners had relegated the more brutal devices to the dark and unenlightened past.

The main protocols adopted in moral therapy at Retreat under Tuke's leadership (Tuke, 1813, pp. 131-187) and at Bicêtre had many practices in common, according to the guidelines proposed by Pinel in his most important book (Pinel, 1806, pp. 48-104; see Appendix 1 for a comparison of the three asylums). Most obvious, both gave particular prominence for the restoration of the mentally ill to ensuring that the buildings in which the mentally ill were housed would be infused with light and space with easy access to the outdoors. Previously the insane had been kept in dark, enclosed prison-like accommodation. Both Tuke and Pinel also emphasised the importance of a good diet, something which had never been a priority. Engaging the inmates in productive work (see Appendix 1) was a particularly important innovation by Tuke and Pinel in their moral therapy programme. In the new bourgeois world of the 18<sup>th</sup> century the major vice, indeed the cardinal sin, was no longer pride or greed but sloth. Thus, the common category that grouped together all those interned in these institutions of social control was their inability to participate in the production, circulation, or accumulation of wealth, for which they were to be punished (Foucault, 1987, p. 68).

The mad, being idle, were a threat to the stability of a bourgeois society in which labour was associated with virtue (Gutting, 2006, p. 55). It was believed that work had a power to constrain which is superior to all other forms of physical coercion. The regularity of the hours associated with a schedule of work, the demands work made on an individual's attention, and the obligation to achieve a result removed what would otherwise have been a harmful liberty of thought, thereby fixing patients in a relationship of responsibility (Foucault, 2006b, p. 485). While psychiatrists analysing moral therapy argued that work could play a therapeutic role by increasing awareness, skills and self-esteem, these justifications were rejected by Foucault who noted that the real motivation of work as a therapy was the Classical Age's beliefs about the morality of work (Gutting, 2006, p. 55).

Foucault believed that the internment to which the mad were subjected in the Classical Age of the 18<sup>th</sup> century concerned not the relations between madness and illness but the relations between society and itself, between society and what it recognized and did not recognize as normal or acceptable in the behaviour of individuals. Thus, the history of medicine and psychiatry (*ante-litteram*) is consistent with Foucault's discourse on power and knowledge. According to Foucault, moral therapy was not a medical and humanist revolution but instead was a fundamental step in the development of knowledge/power practices. Pinel and Tuke did not introduce a scientific approach to the treatment of mental illness but instead "adopted an authoritarian personality" (Foucault in Fontana-Giusti, 2013, p. 65). The practices of moral therapy were meant to "infect man's body" and to provide the means to shape a patient's ideas (Armstrong, 1994, p. 62; Kempt, 1984, p. 95). According to Foucault, what persists from Pinel to Freud is the figure of the doctor as a person not of knowledge but of order in whom "all secret, magic, esoteric, thaumaturgical powers are brought together" (Foucault as quoted in Derrida *et al.*, 1994, p. 245).

Moral therapy required that the mad were subject to the imposition of a 'religious and moral milieu', a milieu which, as noted earlier, Foucault saw as coercive and controlling

(Foucault, 1967, p. 244-245). Moral therapy, emphasised Foucault, was not a type of long-term process whose first and last function would be to bring to light the truth of the madness, to be able to observe it, describe it, diagnose it and, on that basis, to define the therapy. Instead, the therapeutic process formulated between 1810 and 1830 was a scene of confrontation, involving the doctor, the supervisor and the patient (Foucault, 2006, p. 9) whereby surveillance and judgment provided the means to construct a new personage (Foucault, 1967, p. 251).

Consistent with the insistent directions of Tuke and Pinel, to implement his vision of moral therapy, soon after his appointment Pisani started work to renovate the buildings then used by the asylum with the addition of new dormitories and communal areas where the patients were divided by gender and mental illness. The architecture of Tuke's York Retreat, the model for moral treatment, recognised that the way in which spaces were organised and presented was crucial to the restoration of patients. Accordingly, the attention which Pisani gave to the quality and layout of the buildings sought to create conditions necessary to separate and manage those identified with similar symptoms and behaviour. The architectural style chosen by Pisani for the RCM, unlike many other European lunatic asylums, did not adhere to a form modelled on Bentham's panopticon now that there was no need for oppressive physical control (Elden, 2003; Du Plessis, 2012). Instead, the moral therapy which Pisani sought to introduce required the removal of anything that resembled a prison and an endeavour to look more like a healthcare facility (Pignocco, 1855). The rooms, as shown in Figures 1, 2 and 3, were generously housed in a rectangular-shaped building. The layout of the new building provided more light and ventilation, access to indoor and outdoor gardens and used coloured, decorated walls to brighten the building. The "extremely meticulous orderings of space" (Foucault, 1978, pp. 145-146) in the RCM which allowed management to segment the inmates provided the means to use resources more efficiently by codifying or standardising living conditions and treatment within the asylum according to the inmates' diagnosed conditions. As a form of 'institutional architecture' (Armstrong 1994, p. 30), the architecture of the RCM was to prove essential in reinforcing regimes of behavioural change.

**Figure 1.** The architectural style of the RCM (front elevation)



Source: Pisani, 1827, p. 61.





Within a few years, so successful had the RCM become that the number of patients and applications for new admissions increased rapidly to unprecedented levels, from 60 to 130 patients, even though the rules about admissible cases were very strict. To cope with the new requirements for more space, the RCM acquired surrounding land and buildings (De Luca, 1835). In 1837 when the RCM was hit by a cholera outbreak that infested all of Sicily, 52 patients died, about one third of the total. Tragically, Pisani and a doctor, Antonino Greco, who refused to leave and instead chose to remain behind to look after the patients, caught the infection and died (Daita, 1853). Both during and after his time at the RCM the success of moral therapy applied by Pisani was confirmed by the academic studies conducted at the Medical Faculty of the University of Palermo (Inzenga, 1832, 1833) and within a few years the RCM became famous, even beyond Italy. Its reputation was such that illustrious politicians, men of culture and scientists from all over Europe and beyond came to visit, including the Duke of Buckingham and the American poet Edgar Allan Poe (Gambino, 2015).

Immediately after the death of Pisani, the management of the RCM was taken over by his two sons, Melchiorre and Casimiro, neither of whom had any medical qualifications. Only Melchiorre had worked with his father in the administration of the RCM. Thus, not surprisingly, they immediately faced opposition from the doctors of the University of Palermo with the result that at the end of 1837 the two Pisani brothers were removed (Agnetti and Barbato, 1987). In the attempt to placate opponents, the *Luogotenente Generale* appointed as *Deputati* of the RCM Luigi Lucchesi and Epifanio Turrisi, two noblemen with some legal expertise. Unfortunately, they also knew nothing about the treatments used at the RCM, as well as being totally inexperienced in the management of a healthcare facility. They often openly disagreed with each other and were regularly accused of misappropriation of funds, of being abusive to the patients and not using the required therapeutic protocols. Certainly, the two *Deputati* showed little interest in the treatment of the insane, preferring instead to be more concerned with trying to manage administrative problems (Agnetti and Barbato, 1987).

In 1841, the *Luogotenente Generale* appointed as director of the RCM a famous jurist and an experienced manager, Emerico Amari. To support him a medical superintendent, a qualified doctor, was also appointed. Entrusting a doctor with a managerial role was a small revolution in the administrative system of the RCM (Agnetti and Barbato, 1987) which recognised the success of new medical theories applied in Sicily and the prestige acquired by medical science, as formalised and practiced by the University of Palermo (Cancila, 2006). In 1848, the *Luogotenente Generale per la Sicilia* appointed another doctor, Francesco Pignocco, as Director of the RCM, after which it was always to be directed by a doctor. From the 1850s the treatment of madness became part of clinical medicine, leaving the treatment and therapy of mental illnesses to an increasingly specialised branch of medicine.

In the two years that followed Pisani's death, moral therapy continued to be used. However, under the management of Lucchesi and Turrisi the therapeutic protocols used by Pisani were increasingly challenged by organic medicine which gave a priority to the connection between madness and the anatomy and physiology of the human body, rather than to its psychological dimensions (Walk, 1954; Peloquin, 1994).

Pharmacological therapies for the treatment of madness were considered to be more effective and were widely used in other Italian lunatic asylums (Morel, 1846). Thus, between 1849 and 1855 moral therapy at the RCM was supported by pharmacological therapies which began to play an increasingly important role. After the appointment of Francesco Longo, a doctor and professor of anatomy at the University of Palermo, moral therapy disappeared from the therapeutic protocols and was replaced by pharmacological therapy (Costanzo, 1853; Pignocco, 1870; see Appendix 1).

### **Accounting for Moral Therapy: Knowing Mental Deviance**

#### *Medical Statistics*

At the same time that he embarked on rebuilding the RCM, Pisani drew up a body of rules, the *Instructions*, to govern the operations of the asylum and to manage the patients. These were to be the basis of the remarkable moral therapy reforms that he was to bring to the RCM and its residents (Pisani, 1827). Implementing the *Instructions* required adherence to 75 specific Articles or regulations which, as Table 1 shows, were meant to cover all aspects of operations, both financial and medical.

TABLE 1 HERE

Operating the RCM according to the *Instructions* required a highly formalised organisation which, as Table 2 details, specified precisely the function and responsibilities of each office and official, both administrative and medical. The appointment of staff responsible for the financial management of the RCM emphasised the uncertainty of financial support for the RCM.

TABLE 2 HERE

Implementation of the *Instructions* issued by Pisani to manage the clinical operations of the RCM was required to be regularly documented with a wide variety of medical statistics. These would provide the means to implement disciplinary power which acted “by means of general visibility” (Foucault, 1977, p. 171). In the first part of the *Instructions*, Article 16 required that a “register of medical-surgical examinations” should be kept every day (Pisani, 1827, p. 7) while Article 17 added a register to record prescriptions and treatments. Article 28 demanded that a “journal”, to be published once a year, be kept to record each day the “observations of medical practitioners at medical congresses”, the “results of the sectioning of the madmen’s corpses” and “recovered patients” (Pisani, 1827, p. 11). In the second part of the *Instructions*, Article 5 required that a form should be used to collect any information that could be helpful for the patient’s anamnesis and which might be provided by the patient’s family. Article 7 required that the Superintendent had to “write in a register the names, surnames and birthplaces of any readmitted madman the day of their admission, the names of the people who would take them or the authority that would single them out”. Also under Article 7, medical practitioners were to copy information from this register into one which summarised the contents that could be helpful for diagnostic purposes.

At the time of admission of a patient, rather than create a clinical report a file containing the names of those admitted, personal details, marital status, occupation and condition at admission was drawn up for each patient. For destitute people who were unable to pay for their treatment the file also included a court deed that officially certified their state of poverty. These details were summarised in schedules that contained the same information by month (RCM, 1829) and by year (RCM, 1826a). The “*Stato nominativo degli individui dementi esistenti sino a tutto il 18 del mese di marzo anno 1825*” (Alphabetic list of insane at March, 18th, 1825), reproduced here as Figure 4, shows a table from 1826, with seven columns containing the identification number of the patient, the name, the home, the pathology, the admission day, the discharge day and whether the patient was “healed/not healed”.

Figure IV. Details of the Insane

*Notamento degli Individui affetti da orientale alienazione  
forniti guardati dalla B. Casa di Malta nel corso dell'anno 1826*

<i>Numero</i>	<i>Nome e Cognome</i>	<i>Città</i>	<i>Genere di Alienazione</i>	<i>Giorno d'Entrata</i>	<i>Giorno d'Uscita</i>	<i>Osservazioni</i>
1.	Anna Muzio	Salerno	Mania acuta	16 Aug 1826	1 Feb 1827	Guarita
2.	Elisabetta M. Forte	Do	Mania	22 Ag 1826	26 Set 1826	Do
3.	Salvatore Brusca	Così	Mania temporanea	13 Ott 1826	23 Set 1826	Guarita
4.	Emilia Fogliarini	Salerno	Spazzatura	21 Aug 1826	16 Set 1826	Do
5.	Luigia V. Marco	Do	Mania periodica	2 Aug 1826	16 Set 1826	Do
6.	Paolo Paolo Conti	Napoli	Mania indolente periodica	22 Ag 1826	20 Set 1826	Do
7.	Paolo Brusca	Do	Mania epileptica	5 Set 1826	20 Set 1826	Malgrado ogni cura
8.	Giuseppe Cavallaro	Salerno	Melancolia	13 Ott 1826	20 Set 1826	Malgrado ogni cura
9.	Fra Rosario Savarè	Do	Mania acuta	13 Ott 1826	20 Set 1826	Guarita
10.	Maria Leone	Do	Mania acuta con delirio periodico	13 Ott 1826	20 Set 1826	Do
11.	Mariano Sordani	Do	Mania acuta	13 Ott 1826	20 Set 1826	Do
12.	Paolo Costanzo	Napoli	Melancolia	22 Ag 1826	23 Set 1826	Do
13.	Giuseppe Feta	Monza	Mania temporanea	22 Ag 1826	23 Set 1826	Do
14.	Provincenza Malinconica	Salerno	Mania con delirio	22 Aug 1826	23 Set 1826	Do
15.	Carolina Angilone	Do	Mania acuta	22 Aug 1826	23 Set 1826	Do
16.	Giuseppe Torvati	Do	Melancolia	22 Aug 1826	23 Set 1826	Do
17.	Maria Ignazia d'Aliphi	Do	Mania indolente periodica	22 Aug 1826	23 Set 1826	Do
18.	Fra S. Agostino	Vicenza	Guariti dalla Melancolia			Nota in appendice
19.	Antonio Corigliano	Vicenza	Guariti dalla Mania acuta			Nota in appendice
			Guariti nell'anno 1826	19		
			Morti	5		
			Restano in cura (domani)	2		
			Donni	32		
			Uomini	11		

Source: RCM, 1825a.

The large volume of data collected every day in the registers was processed and displayed in many statistical schedules and gathered into reports, some of which were

publicly disclosed. These details had particular financial importance when public funding was in part fixed and part depended on the number of patients. The first statistical report covering the years 1825 to 1834, the period during which Pisani managed the RCM, was drawn up by Dr Antonino Greco, a general practitioner seconded to the RCM and a member of a Statistics Committee Appointed by the Royal Medical Academy of Palermo. In the Introduction to the report, Greco (1835, p. IV) points out that he based it on the work of

the famous Esquirol, who takes the lead in such matters, and took inspiration from the statistic tables he produced himself for the great Dictionary of Medical Science, and did not do much more than change them, or amend them, where I deemed fittest.

Greco produced 18 tables which covered: classification of patients by season of admission, age, occupation, cause of madness, birthplace; recovery by year, length of treatment, kind of madness, season of the year, age of recovered patients; death rate by year, epoch, kind of madness, season, age and cause of death. One table, which is reproduced here as Table 3, summarised the results of the treatment of patients according to gender.

TABLE 3 HERE

Another table, here Table 4, summarised results according to both gender and the type of madness. The recovery rates provided by Greco confirm that the RCM had strong claims to be regarded as a successful mental facility.

TABLE 4 HERE

Those admitted to the lunatic asylum at Palermo might be any age and, as seen in Table 5, came from all walks of life.

TABLE 5 HERE

Table 5 shows that the greatest proportion of patients consisted of lower-middle and middle middle-class professionals or businessmen, although the upper-classes were well represented as were clergymen and servicemen. Remarkably, there were very few members of those classes that had always been marginalised by society, the poor and convicted criminals. Recording the patients' occupation had both a medical and an economic purpose. At the time there was a widespread belief that some occupations were more at risk of mental illness than others. Thus, recording a patient's occupation was thought to help make a diagnosis. Occupation was also suggestive of the ability to pay the fees and of a family's interest in taking the patient back once recovered. A highly innovative aspect of the classification of patients was according to the "causes of madness", as shown in Table 6, which were indicative of the new insights provided by psychiatry at the time. Of particular importance is the unusual understanding of causes of mental illness arising from both physical and emotional problems.

TABLE 6 HERE

After the appointment of Pignocco following the deaths of Greco and Pisani, reports were modelled on those of Pinel, Esquirol and Spurzheim. Pinel had emphasised the importance of statistics at the service of psychiatric treatment while Esquirol used statistical tables and rating criteria. Unusually, Spurzheim gave central importance to comparing figures with other lunatic asylums in Italy, other parts of Europe and England (Pignocco, 1839, pp. V-VII). Many pages are spent discussing the causes of madness, using the same classification by physical and moral causes as the one first introduced by Pinel and Esquirol. An important innovation was the comparison of the average recovery rates with those of the best-known asylums of the time, including the hospital of Bicêtre, the detention house of Paris, the Bethel in London and hospitals at York, Berlin and Vienna. Pignocco points out that the mean recovery rate of these leading institutions was approximately 35-40%, to which the RCM compared favourably (Pignocco, 1839, p. 33). This was another novel, innovative means in the exercise of disciplinary power to construct the authority needed to establish and implement norms for behaviour. Reference at the time to practices elsewhere, but especially institutions with a well-recognised reputation for effective treatment of the mentally ill, was in effect a form of test upon which disciplinary regimes rely (Armstrong, 1994, p. 27). It was a means to create “a general recipe for the exercise of power over men” which was at the heart of “regimes of truth” (Foucault, 1977, p. 102).

Before he left the RCM, Pignocco compiled a volume covering the years 1841-1849 with a statistical supplement (Pignocco, 1850). The volume has just eight tables which provide details about: time of admission (Table I); recovery rates and death rates (Table II); seasons of admissions (Table III); length of hospitalisation, recovery rates, death rates and number of patients (Table IV); types of madness of discharged or dead patients (Table V); age at death (Table VI); cause of death (Table VII) and the birthplace of the admitted, discharged and dead patients prorated to the total resident population of Sicily (Table VIII). The last statistical report for the RCM was prepared in 1858 by Rosario Gebbia, a doctor at the RCM, covering the years 1852-1855 (Gebbia, 1858). Gebbia, as did Greco and Pignocco, expressed his debt of gratitude to the statistical method developed by Esquirol whose “famous tables leave little to be desired ...” (Gebbia, 1858, pp. 10-11). Gebbia (1858, p. 3) describes the purpose of the report as to

infer the phases of asylum of a family of mad people from the number of cured and dead patients per year compared with the existing mass; the other to know the relationship between the outcomes of madness, recovery, death, and the cure of various types, or because of the conditions in which the patients found themselves relative to age, gender, season, climate and treatment of each lunatic.

### **Financial Statistics at the RCM**

The information collected by the RCM, as required by the *Instructions*, was to be the means by which the inmates could be managed according to the precepts of moral therapy, whereby treatment would be managed by identified categories of illness. The clinical evidence became a crucial source of information upon which the financial accounts were prepared. Articles 54 and Part Two of the 1827 *Instructions* specified the

way the bookkeeping role was to be carried out and which account books had to be kept at the RCM. Indicative of the importance for the successful delivery of moral therapy which was given to good financial management, an accountant was appointed who was responsible for records of revenues, expenses and inventory and a collector was appointed to manage bank accounts and collect payments (Pisani, 1827, pp. 26-29; see Table 2 above).

Immediately after Pisani's appointment, the Plan of Initial Expenditures for the Facilities of the House of Madness of Palermo, the equivalent of the modern business plan, was drawn up by a dedicated Advisory Committee appointed by the King on 22<sup>nd</sup> September 1824. Table 7 shows the expenditures necessary to implement the plan, which were based upon a maximum capacity of 100 beds for patients mainly from Palermo and surrounding areas. A new lunatic asylum which would be able to serve all of Sicily would need an increase in the budgeted number of beds and, as a consequence, would incur significantly higher costs. To ensure that his plan was accepted by the Advisory Committee, Pisani did not challenge their estimated costs. This meant that he had allowed the Superintendent to underestimate the costs for the conversion of the hospital (RCM, 1824a).

#### TABLE 7 HERE

From the RCM's first year of operations a brief yearly business plan, or budget, was produced. This very general statement of financial needs, as shown in Table 8 for 1824, was seen as but one element in the efficient management of the RCM.

#### TABLE 8 HERE

This summarised budget was complemented by the Monthly Food Cost Budget, as shown in Table 9. This budget gave details of the type of food available to inmates and between 1819 and 1824 provided a thorough analysis of the average monthly expenditure. This was then taken as a standard cost, as a comparison for the yearly budgets and the final reports (ASP, 1824).

#### TABLE 9 HERE

Pisani needed to mediate between a social and therapeutic purpose; between good physical health as a prerequisite for good mental health and the financial constraints imposed by what were in effect standard costs for treating the patients. In this process accounting was meant, in effect, to 'panopticalise' the management of the asylum. As the basis upon which contributions from the government would be determined, a standard cost for each patient was imposed on the RCM by the Advisory Committee that stipulated the amount of each type of food other necessities that could be allocated to each patient. The standard costs and quantities promoted the intention that the patients would be their own disciplinarian. The 'inspecting gaze' that was created would mean that "each individual under its weight will end by internalising to the point that he is his own overseer" (Foucault, 1980, p. 155). The individual, note Miller and O'Leary (1987, p. 243) attends "to his or her own deficiencies .... (T)he individual becomes an auto-

regulated entity”. Thus, the impact of a regulated diet was meant to ‘infect’ an inmate’s body and mould their ideas (Stewart, 1992, p. 62). They would know that there were limits to that which could be provided by the RCM and that they would have to control their demands.

The standards also recognised the asymmetry of power emphasised by Foucault between the practitioners of the new science of psychiatry and their subjects, the patients, and thereby reinforce the required norm. Standards were part of disciplinary regimes which enabled hierarchical observation by making each person a part of an identified group, a documented case (Foucault, 1977, p. 209; Armstrong, 1994). The normalising judgement sought to correct behaviour which contradicted that which was approved and sanctioned by society. For Foucault, standards or benchmarks were measures of normality, the means to impose expected behaviour and to identify deviations from the expected. Accordingly, the meal allowances provided a potent means of disciplining patients. The standard allowances communicated beliefs about what constituted good physical health which would be the path to mental well-being. A cost sheet with details of the fabrics, clothes, linen used at the RCM, was separately drawn up and was based on consumption per patient, not per day (RCM, 1824c). These innovations meant that accounting became a disciplinary power to make the patients knowable and, thus, to be disciplined to produce “docile bodies” (Burchell *et al.*, 1985; Hoskin and Macve, 1986, 1988; Loft, 1986; Knights and Collison, 1987).

The main variable cost items depended on each patient’s daily meals and treatment. Recognising the important contributions of a patient’s diet to their recovery, they had a more balanced diet with milk, coffee, eggs, and nuts (Pisani, 1827, pp. 56-59). The last section of the *Instructions* shows that the daily diet of the destitute, that is non-paying, patients included nearly two kilos of bread, 200 grams of pasta and 300 grams of meat. For dinner, there would be a hot dish in winter and cheese and salad in summer. The quantity and quality of the destitute patients’ diet were even better than that of small or medium-sized farmers and craftsmen. Paying patients had a more varied diet and they stayed in better lodgings, upstairs in the main building, while destitute patients stayed downstairs in less generous, but still considerably improved, accommodation (Pisani, 1827, pp. 58-9).

The standard cost per patient was not only designed to monitor the efficiency of the institution but also to set the fees. The 144-ducat fee introduced by Pisani for paying patients (Pisani, 1827, p. 27) was easily affordable by the upper middle classes and by the professional or merchant middle classes. The fee, however, was beyond the reach of the vast majority of the population who would continue to rely upon contributions from wealthy individuals and public bodies. In addition to the fee paid by paying patients, a fixed fee for each patient was paid by government bodies. Table 10 shows the sources of funds from public bodies, with the smallest amount, 400oz, coming from the local government of Palermo. Much of the remainder, 2200oz, was provided by the other main Sicilian municipalities, prorated according to their population who were the potential users.

TABLE 10 HERE

Once the RCM was refurbished and operating according to the program of moral therapy, Pisani realised that he had to make the sources of funding more certain. If the RCM was to survive and become a leader in the care of the mentally ill, it would require careful management of what were mostly very uncertain financial resources. This would be especially relevant for Pisani's plans for urgent investment in new facilities consistent with the methods and aims of moral therapy. The lack of adequate, reliable funds had been a persistent problem faced by the lunatic asylum of Aversa ten years earlier. Thus, the information contained in the statistical reports provided the evidence which the RCM needed to convince both the government and private benefactors to provide the necessary resources to deliver its services. The Bourbon government was reluctant to support the ongoing costs of such works, preferring instead to shift the costs on to municipal bodies or to any private institution concerned. The variety of sources of funding meant that often collecting the money was fraught with considerable uncertainty, with supporters' frequently late and irregular with their payments, making it very difficult for Barone Pisani and the managers that came after him.

By opening the asylum to the mentally ill from throughout Sicily, Pisani could negotiate with the Advisory Committee to make all the island's provinces share the RCM's running costs. Above all, Pisani reassured the *Luogotenente* that with certainty about the consistency of the asylum's financial flows he would be able to admit up to 130 patients. Each paying municipality would have a quota of free places for the poor, whose status had to be certified by a municipal Certificate of Destitution (Pisani, 1827, p. 26). If the number of patients exceeded 130, the municipalities would have had to pay 90 ducats a year per patient, even for the poor patients, instead of a fixed contribution. The Article stating that the poor should be kept for free at the RCM until the number of patients reached 130 was soon voided when the threshold was exceeded as early as 1828. When the municipalities made it clear that they were not prepared to pay a variable fee of 90 ducats a year they refused to grant applications for hospitalisation for their poor with the excuse that destitution was difficult to certify.

More regulated sources of income were supplemented with bequests and donations from the patients' relatives or heirs, who were usually from the noble or upper classes (RCM, 1825b). An increasingly important source of revenue was the goods made by patients and the services that they provided in the running of the asylum. Items made by patients were a crucial part of the moral therapy which had both a therapeutic purpose and sought to promote the patients' working skills. Indeed, many of the RCM's patients were employed as craftsmen while at the RCM, usually in the same crafts they had engaged in when they were "normal". Thus, furnishings, decorations, paintings, tools, clothes, small repairs, gardening, cleaning were not outsourced, thereby helping to reduce costs (Pisani, 1827, pp. 21, 28, 41). Accordingly, the effectiveness of the medical treatment which included the need for patients to be engaged in productive activities had a favourable impact on the organisation's efficiency, strengthening its reputation as well as its economic viability by reducing the costs the community had to bear.

The RCM had to negotiate its own budget with the government, although it was not the overall amount that had to be negotiated but each cost item. An example, the 'negotiated budget' for 1834-1835, is provided in Table 11.

#### TABLE 11 HERE

From the accounting reports it is clearly seen that the RCM was expected to keep a high level of accountability to survive and that the effective treatment of patients was predicated on strong financial management. Moral therapy could not endure unless the RCM could ensure stability and the conditions essential to the methods of moral therapy. This meant that cost estimates and effective cost control were prerequisite conditions when engaging in negotiations with the public institutions providing funding.

### Conclusions

Moral therapy emphasised rational and emotional causes of insanity, rejecting the primacy given to the organic and the need to separate, even incarcerate, the mentally ill from the rest of society. The aim of moral therapy was to provide a therapeutic environment which encoded in the design and management of the institution the sensations, expectations and behaviours which would provide the means to transform the behaviour and beliefs of the patients according to those proclaimed as normal by psychiatry. Thus, the RCM changed the previous accepted form of control to enable the mad to live healthy lives for they were now "considered to have the same sensorial awareness as the sane" (Edginton, 2007, p. 86). To implement their vision of moral therapy, Pisani and his successors at the RCM sought to create "total institutions" (Goffman, 1968) which were characterised by "a continuous exposure of their inmates to a certain moral and material order ..." (Armstrong, 1994, p. 41). Accordingly, the beliefs of moral therapy were operationalised through routines of behaviour which were specified in great detail with daily programmed activities conducted within buildings which were designed and built to promote mental well-being.

Pisani's *Instructions* and the architecture of the RCM sought to create a form of discipline devoid of physical force and punishments to produce subjected bodies where there was a "link between an increased aptitude and an increased domination" (Foucault 1977, p. 138). From the late 18<sup>th</sup> century there had been an increasing appreciation of the way in which spatial influences could affect behaviour and, thus, influence moral management of mental patients (Edginton 2007, p. 85; Topp and Moran, 2007, p. 1). The form of the physical space created at the RCM and the attendant forms of therapy that this permitted recognised the dependent relationship between the way in which space is defined and power exercised through the "encoding of their relations" (Foucault in Leach, 1997, pp. 376-377). The architecture of the RCM was to "reflect and contribute to the moral and ethical" well-being of the inmates, to be the means to establish emotional relationships (De Zurko, 1957, p. 11). The redesigned buildings of the RCM for the purpose of moral therapy were the result of political structures pursuing moral objectives. Within this context, the achievement of 'moral domination' of patients, upon which the success of moral therapy depended, relied upon the knowledge provided by numerous sources of information about the patients and their treatment.

The array of medical and financial statistics generated by the RCM made possible “the measurement of overall phenomena, the description of groups ..., the calculation of gaps between individuals, their distribution in a given population” (Foucault, 1977, p. 190). Individuals could be identified and constructed as objects which would then be governable (Foucault, 2008, p. 103). In particular, Pisani realised with the issue of his *Instructions* that the accounts of the RCM gave access to a realm of knowledge which he believed was essential to the success of moral therapy. Accounting was not exclusively a neutral, benign tool of economic rationality but instead was profoundly implicated in a creative, redemptive process which required the exercise of a form control over the lives of the inmates of the RCM (Miller and O’Leary, 1987).

Medical and financial statistics based on the methodological standards adopted by the RCM and used throughout Europe in the 19<sup>th</sup> century were used to classify and trap people in very specific categories, to provide evidence of multiple aspects of their admission that were of interest to the lunatic asylum, to the community that supported it, and to the scientific community. This power-knowledge relationship was used as the means to understand the way in which patients could be known and, therefore, the way in which they could be treated. Accounting practices used by the RCM highlight “the diversity of forces and groups that have, in heterogeneous ways, sought to regulate the lives of individuals...” (Miller and Rose, 1990, p. 3). Accounting practices allowed the programmes of moral therapy to become thinkable and thus enforceable. This information was used by the lunatic asylum to give public visibility to the nature and standard of its work which was essential to maintaining financial support from affluent sections of the public and government.

Accounting provided information that helped to understand and control mental deviance, one of the conditions least known and most feared by the aristocratic and bourgeois society of the time. Accounting and accountability practices can shape, almost imperceptibly, the behaviour of individuals, rendering the centralization and concentration of power possible (Sargiacomo, 2009; Gatti and Poli, 2014). Accounting helped to create compliant, accepting subjects (Hoskin and Macve, 1988; Miller and Rose, 1990) and to secure the implementation of the programmes of moral therapy (Neu, 2000; Maran *et al.*, 2016). It was an invaluable tool for securing the cooperation of individuals in their own subjection to power by helping to create the conditions which would enable the moulding of identities (Baños *et al.*, 2005, pp. 207-208). It was profoundly implicated in the reproduction of power relations in the RCM and more broadly in society according to the values of the bourgeoisie (Miller and O’Leary, 1987; Hoskin and Macve, 1986, 1988).

With the confinement of the insane having a social cost as much as a social justification, by fulfilling a number of functions accounting was very important in justifying the RCM’s work, legitimising it, and fulfilling its accountability to external parties. At the RCM, accounting was used to justify costs that society was asked to bear to contain a perplexing illness in a charitable and acceptable way according to the moral standards of the time. Accounting information allowed the RCM to prove how well it conducted its work and the importance of a lunatic asylum.

The findings of this study provide the opportunity for researchers to examine other mental facilities in Europe and elsewhere from the rise of modern psychiatry in the 19<sup>th</sup> century to the present day. This is especially relevant given the importance which the history of the mental asylum has for understanding the genesis and applications of Foucault's influential insights into the manner in which power is generated and sustained. Examination of asylums in England and France which provided the models for the Pisani and the RCM provide exceptional opportunities for accounting scholars to expand both our understandings of accounting as an implement of healing and as a set of practices which are critical to the acceptance and exercise of power.

## Appendix 1

### Moral therapy in RCM compared with Pinel's and Tuke's Approaches

Feature	Pinel	Tuke	RCM
Admission		At the doctor's request. Only for lunatic members of the Society or their relatives	Proposed by the <i>Luogotenente Generale</i> and ordered by the Managing Director
Division by social class		Divided into upper class and lower class.	The institute pays for the poor ones, while the wealthy ones pay for themselves.
Anamnesis	Psychiatric anamnesis of the patient.	Anamnesis provided by the doctor.	Notes shown by the people taking in the patient.
Separation from family and friends	Confinement	Occasional visits allowed.	Separated from family and friends
Bathing	No cold baths. Warm baths in some cases.	No cold baths. Warm baths for relaxation.	On entering, they are taken to a warm, scented bath.
Medical examination		One doctor present.	Patients examined for non-psychiatric conditions and for their mental illness.
Diagnosis	Accurate determination of the type of mental disorder.		In consultation between the doctors and the general manager
Allocation	Lunatics allocated to different wards, based on illness, and men/woman wards.	No uniform. Divided by gender.	Divided by gender. Lunatics allocated to different wards, based on illness, and have to wear a uniform.
Buildings	Open and bright.	No restraints that the patient can see. Gardens.	Open and bright.
Cleanliness	Everything must be clean.	Everything must be clean.	The patients' underwear and clothes are changed every Sunday or when dirty.
Diet	Planned	Planned	Planned

Pharmacological treatment	Laxatives or antispasmodics.		
Occupational therapy	Manual and farming work.	Light manual work.	Manual and farming work.
Play	Playful activities that distract the patients from their manias.	Reading.	Regular physical and mental exercise.
Timing	Scheduled.	Daily routine.	Scheduled activities, punctuated by the ringing of a bell.
Religious services		Yes.	Yes.
Restraints	Forbidden. In the event of a violent outburst, detention with light food and a straitjacket.	Moderate use of straitjackets.	Only in the event of a violent outburst, with a straitjacket or confinement in their room.
Convalescence	Convalescents are separated from the other patients and can interact with healthy people.	Convalescents are separated and can interact with healthy people.	On confirmation of recovery, three months in special rooms, with their clothes back.
Rehabilitation	Lunatics are gradually brought back to their usual occupations.		Escorted outings, eating with the doctors and the superintendent, relatives may start to visit them under supervision.

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