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Gendered denials: Vulnerability created by barriers to legal capacity for women and disabled women

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ABSTRACT

This article explores the vulnerability that is created when legal capacity is denied to women and disabled women. It argues that vulnerability is largely contingent on social constructs – as opposed to being an inherent quality of disability or gender. It discusses barriers to the exercise of legal capacity that women and disabled women experience – such as limitations on reproductive choice, higher rates of substituted decision-making, and unique experiences with forced mental health treatment. It then explores evidence that such barriers are disempowering and can leave women and disabled women vulnerable to abuse and marginalisation. It explores financial, physical and sexual abuse that can occur as a result of this vulnerability. Finally, it concludes that autonomy and power are inextricably linked and can be essential for minimising vulnerability.

1. Introduction

Vulnerability is a powerful concept. When it is ascribed to an individual or to a group of people, it can transform their social world (Boyle, 2003). A vulnerable person is often treated differently – they are thought to deserve higher levels of external protection, which frequently results in lower levels of autonomy and self-determination (J. Anderson, 2013; J. Anderson & Honneth, 2005; Rogers & Meek Lange, 2013; Scully, 2013). Sometimes people can benefit from being labelled as vulnerable. For example, more money may be expended by the government to provide support for groups labelled as vulnerable. However, frequently, groups labelled as vulnerable also experience significant negative repercussions of such labels. They are often inaccurately identified as weak, powerless, and ineffectual (Gill, 2006; Hollander, 2002; C. Levine et al., 2004; Scully, 2013). The vulnerability that they may be experiencing is often mistakenly identified by state actors as well as others as vulnerability inherent to the individual, not vulnerability created by their social environment. In addition, these qualities are often ascribed to all individuals within a group labelled as vulnerable, without distinctions drawn between individuals (Luna, 2009; Scully, 2013). This can be profoundly disempowering, which may, in turn, beget more vulnerability.

Women and disabled women are often labelled as vulnerable (Butler, Gambetti, & Sabsay, 2016; Hollander, 2002; Luna, 2009; Scully, 2013).[1] They are often subjected to the externally imposed notion of the 'vulnerable female subject.' However, the realities of how women and disabled women experience vulnerability is often much different from this externally imposed notion. In addition, this concept of the 'vulnerable female subject' can operate to reinforce marginalisation and limit women and disabled women's choices (Lajoie, 2018). Furthermore, this vulnerability labelling creates a power dynamic which favours those who are not labelled as vulnerable. This can also limit the choices and autonomy of those groups – such as women and disabled women – who are labelled as vulnerable (Boyle, 2003).

In order for an individual to have their autonomy respected on an equal basis with others, they must have their legal capacity recognised. Legal capacity is an individual's legal personhood and legal agency. Denials of legal capacity and barriers to legal capacity – such as the imposition of guardianship, the denial of reproductive choice, and denial of decision-making in psychiatric settings – are experienced at a higher rate and in a unique manner by women and disabled women. This is partially because of the label of vulnerability, which can precipitate an assumption of a need for increased protection. These denials of legal capacity and barriers to legal capacity create additional vulnerability amidst these groups due to the profoundly disempowering nature of autonomy removal that comes along with limitations on legal capacity. This article explores some specific situations in which this may be occurring and why. Finally, it concludes by arguing that this

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[1] Women and disabled women are identified as separate groups in this article in recognition of the unique social barriers that disabled women face. It should be noted that these groups are overlapping and intersecting.

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connection between limitations on legal capacity and the construction of vulnerability has been overlooked in law and public policy and needs to be adequately addressed.

2. Vulnerability as a social construct

Vulnerability exists where an individual lacks control over events that may jeopardise things that are important to that individual (J. Anderson, 2013). It is almost always used in the context of negative phenomena – an occurrence that is either undesirable to the individual or viewed as undesirable by others (Pritchard-Jones, 2018; Scully, 2013). It is directly contingent upon the power relations of an individual and the forces that are impacting them. If the individual gains power over those forces, vulnerability decreases. If the individual loses power over those forces, vulnerability increases (Anderson, 2013).

Losses or gains of power over forces impacting an individual may occur due to losses or gains in autonomy (Anderson, 2013). For example, if all funding for disability services goes directly from the government to the service provider – and the disabled person does not have autonomy to make choices regarding the distribution and use of that funding – then, the disabled person lacks control over their disability services. These services are often essential for an individual's daily activities. In this situation, the disabled person is vulnerable to the decisions of the service provider, which may or may not align with what the individual desires for themselves. If the disabled person had autonomy to make decisions regarding some or all of the funding going to the service provider – and was provided with access to appropriate support for exercising that autonomy – then, the vulnerability of the disabled person, in relation to the service provider, would decrease. As such, vulnerability is intimately tied to power relations, which are subject to change based on the relative autonomy of the parties (Anderson, 2013).

Jackie Leach Scully has identified two perspectives of vulnerability. The first is when vulnerability is viewed as ontological – an inescapable aspect of all people's lives. This is vulnerability that everyone is susceptible too, such as, illness, injury, or death (Scully, 2013). This perspective of vulnerability is commonly seen in legal theory and bioethical scholarship. For example, Martha Fineman has noted that vulnerability is "universal and constant, inherent in the human condition" and has used this perspective of vulnerability to reimagine the socio-legal order in a manner which accounts for vulnerability and dependence (M. Fineman, 2004; M. A. Fineman, 2008; M. Fineman & Grear, 2013; Matambanadzo, 2012; Scully, 2013). This perspective of vulnerability does not ascribe vulnerability based on group membership. Instead, it discusses vulnerability as a universal trait (Butler et al., 2016; Matambanadzo, 2012; Scully, 2013). The downside of this perspective is that it risks overlooking the particular vulnerabilities that certain individuals face – especially those due to group marginalisation, such as is experienced by disabled people. For example, inaccessible public buildings and services, as well as overt discrimination on the basis of disability.

The second perspective of vulnerability that Leach Scully has identified is when particular groups are singled out as especially vulnerable (Scully, 2013). This has also been identified as a 'status-based' approach to vulnerability (Pritchard-Jones, 2018). This perspective of vulnerability is often adopted in research, medical ethics, and public health ethics. This perspective assumes that by virtue of an individual's status, or group membership, they are especially vulnerable to harm (Pritchard-Jones, 2018; Scully, 2013). The downside of this perspective is potentially even more dangerous than that of the first perspective – it creates a dichotomy in which the social world is divided into two groups. The first is a group that is 'normal' and invulnerable enough to have their autonomy largely respected and to be left to carry on with their lives. The other group is a 'special' group which is viewed as abnormal and particularly vulnerable to harm. This 'special' group is believed to need differential treatment in order to either restore them to normality or to limit their autonomy in the name of protection (Scully, 2013). This is dangerous because the two groups are often ascribed different rights and responsibilities – the 'normal' group is granted the full gambit of rights and responsibilities, whereas the 'special' group has limited rights to autonomy and will often be deemed to not be held responsible for their actions on an equal basis with members of the 'normal' group. Disabled people are often relegated to the 'special' group and are subjected to these altered – and often disadvantageous – rights and responsibilities (Arstein-Kerslake, Gooding, Andrews, & McSherry, 2017). Leach Scully argues instead for an expanded view of ontological vulnerability which encompasses vulnerability created by social dependence (Scully, 2013). This would allow for the acceptance of vulnerability as a universal trait, while also drawing attention to socially constructed vulnerability that could be addressed and corrected.

In addition to the two different perspectives of vulnerability, Leach Scully has also identified two different types of vulnerability in relation to disability – 'inherent' and 'contingent' vulnerabilities. Inherent vulnerabilities are those which are often due to a physio-logical or biological characteristic of the individual. For example, physical weakness or chronic pain. These are vulnerabilities which the social environment may be changed to accommodate, however it would be difficult or impossible for changes in the social environment to fully negate these vulnerabilities (Scully, 2013).

Conversely, contingent vulnerabilities are those that are directly created by the social environment – they are contingent on social phenomena that instigate and perpetuate situations and phenomena that create vulnerability (Scully, 2013). For example, an environment, such as a public bathroom, that has not been made physically accessible for a person using a wheelchair and requires the individual to depend upon another person to utilise it. This leaves the individual using the wheelchair vulnerable to the other person because they are faced with a need to use the bathroom, but they are dependent upon the other's assistance. The other person holds power in this situation and may abuse that power. This is vulnerability that is contingent on the inaccessible environment. If the public bathroom was made accessible – with automatically opening doors, appropriate space for a wheelchair, the toilet, and other mechanisms at appropriate heights, etc. – then the individual may be able to utilise the bathroom on their own and may not need to depend on another person. The individual using the wheelchair would, therefore, not be vulnerable to the potential for the other individual to abuse their position of power and do harm to the individual using the wheelchair.

There is a misperception that inherent vulnerabilities are more common for certain groups – especially minority groups, such as women and disabled people (Hollander, 2002; Scully, 2013). However, many vulnerabilities that are perceived to be inherent vulnerabilities, may actually be contingent vulnerabilities. For example, people with intellectual disability are often perceived as possessing the inherent vulnerability of poor decision-making skills. Poor decision-making skills are perceived as a vulnerability because they may make an individual more prone to suggestion and undue influence as well as prone to making bad decisions that may lead to harm to themselves or those around them. For many people with intellectual disability, this is simply a misperception and they, in fact, possess very good decision-making skills. For other people with intellectual disability, they may have difficulty with decision-making skills, however this may be due to being denied opportunities to develop decision-making skills, due to a lack of accessible information regarding particular decisions, due to an anxiety-producing or otherwise unfriendly environment for decision-making, or due to many other factors that are socially constructed or can be accommodated through the social environment. Where this is the case, such vulnerabilities are not inherent vulnerabilities, but are instead contingent vulnerabilities which can be lessened or eliminated through changes to the social environment.

Some may argue that women are inherently more vulnerable simply

due to biological reasons, such as lesser physical strength on average than men (Hollander, 2002). It is true that in some situations varying levels of physical strength alone may lead to certain individuals, with less physical strength, experiencing inherent vulnerability when physically challenged by an individual of greater strength. However, if physical strength was an indicator of social power or privilege, then physical strength would be a prominent characteristic of the extremely wealthy, law makers, CEOs, and others who experience high levels of social power and privilege. This is generally not the case. Instead, it is often those of lower social standing that develop physical strength due to work that requires high levels of manual labour and is generally poorly remunerated. Such groups of lower social standing are, in many ways, more vulnerable than those with less physical strength but high social power and privilege. For example, they generally have less monetary freedom, lower education levels, and less political decision-making power. In this way, the argument that women are inherently more vulnerable due to biological differences in physical strength is inconsistent with the wider population, in which it seems that those with the highest levels of physical strength are often in positions of less power and greater social vulnerability. As such, even physical weakness could be considered a contingent vulnerability that can be accommodated for, or balanced out, by social phenomena.

Perceptions of vulnerability are strongly linked to recognition of autonomy and the granting or denial of legal capacity. Women and disabled women are often overly ascribed with inherent vulnerability (Butler et al., 2016; Hollander, 2002; Scully, 2013). As such, they are disproportionately viewed as needing a higher degree of protection than other groups. This has resulted in the denial of autonomy – including the denial of legal capacity – in various contexts, which will be explored below. These denials of autonomy lead to an increase of contingent vulnerability, which is further mistaken as inherent vulnerability. This becomes a cycle of vulnerability labelling because it then feeds back in to the existing notion of women and disabled women as in need of special protection and as incapable of directing their own lives or making legal decisions on an equal basis with others.

3. Legal capacity barriers for women and disabled women

3.1. Defining legal capacity

Legal capacity is the law's recognition of an individual, or other entity, as a legal person and a legal actor (Office of the United Nations High Commissioner of Human Rights (OHCHR), 2005). The right to legal capacity of disabled people had not been given significant scholarly or other attention until the 2006 United Nations Convention on the Rights of Persons with Disabilities (CRPD). Article 12 of the CRPD establishes the right to legal capacity as part of the right to equal recognition before the law (Arstein-Kerslake & Flynn, 2016b; Committee on the Rights of Persons with Disabilities, 2014).

The individual rights and state obligations emanating from Article 12 have been illuminated by the United Nations Committee on the Rights of Person with Disabilities (CPRD Committee), which is the monitoring body for the CRPD. They wrote their first General Comment on the right to equal recognition before the law in Article 12 (Arstein-Kerslake & Flynn, 2016b; Committee on the Rights of Persons with Disabilities, 2014).[2] A General Comment from a United Nations Human Rights body is an explanation or interpretation of international law in a particular field or area. They are considered to be authoritative interpretations of international law (Mechlem, 2009).

The General Comment on the right to equal recognition before the law outlines key areas of life that the right to legal capacity commonly impacts. For example, legal capacity must be recognised in order to vote, marry, contract, inherit, consent to sex, consent to medical treatment, consent to mental health treatment, and any other area of life that requires a legal decision to be made and respected (Arstein-Kerslake, 2017; Arstein-Kerslake & Flynn, 2016b; Committee on the Rights of Persons with Disabilities, 2014; Flynn & Arstein-Kerslake, 2014). Importantly, the General Comment differentiates legal capacity from mental capacity. Legal capacity is an individual's recognition as a legal person and legal agent. Mental capacity is a distinct concept, it is an individual's decision-making and cognitive skills. The General Comment states that, in accordance with Article 12, legal capacity is a right of every individual and should not be denied on the basis of mental capacity (Committee on the Rights of Persons with Disabilities, 2014). Instead, legal capacity should be respected in every individual and, where an individual experiences difficulty with mental capacity, the state has an obligation to provide access to support for that individual to utilise their mental capacity to exercise their right to legal capacity. In the narrow range of circumstances where this is not possible, a decision can be made in line with the best interpretation of the individual's will and preferences (Arstein-Kerslake & Flynn, 2016b; Bach & Kerzner, 2010; Committee on the Rights of Persons with Disabilities, 2014; Flynn & Arstein-Kerslake, 2014). In this article, when the term 'legal capacity' is used, it is referring to the individual's recognition as a legal person and legal agent.

The General Comment on Article 12 also states that the right to legal capacity requires that states move away from substituted decision-making systems and replace them with systems of support. It defines substituted decision-making systems as those in which: "(a) legal capacity is removed from a person, even if this is in respect of a single decision; (b) a substitute decision maker can be appointed by someone other than the person concerned, and this can be done against his or her will; or (c) any decision made by a substitute decision maker is based on what is believed to be in the objective 'best interests' of the person concerned, as opposed to being based on the person's own will and preferences" (Arstein-Kerslake & Flynn, 2016b; Committee on the Rights of Persons with Disabilities, 2014, 2018; Donnelly, 2016). This has significant implications for many existing areas of the law, including: guardianship, mental health, consent, and others (Arstein-Kerslake, 2015, 2017; Donnelly & Murray, 2016; Flynn & Arstein-Kerslake, 2014; Brendan D. Kelly, 2014; Weller, 2014).

In line with the text of Article 12(4), the General Comment explains that systems of support must respect the rights, will, and preferences of the person in a manner that is non-discriminatory (Arstein-Kerslake & Flynn, 2016b; Committee on the Rights of Persons with Disabilities, 2014; UN General Assembly, 2007). This support can come in various different forms, ranging from the provision of accessible information necessary for making a legal decision to the practice of supported decision-making – where one or more individuals provide assistance to an individual in the process of making a legal decision (Flynn & Arstein-Kerslake, 2014; Joanne Watson, 2016).

There has been resistance to the CRPD Committee's interpretation of Article 12. For example, prior to the creation of the General Comment, some states, including Canada, Norway, and Australia had lodged reservations to Article 12, articulating their interpretation of Article 12 as permitting legal capacity denial and substituted decision-making in certain circumstances (Bartlett, 2012; Edwards, 1989; Hoffman, Sritharan, & Tejpar, 2016; McCallum, 2010). The CRPD Committee has stated that these interpretations are inconsistent with the Committee's interpretation of Article 12 and with the overall object and purpose of the CRPD (Committee on the Rights of Persons with Disabilities, 2017).

Importantly, other jurisdictions have gone forward and achieved significant reform in line with the CRPD Committee's interpretation of Article 12 (Martinez-Pujalte, 2019). For example, in 2018, Peru reformed its civil code to remove all restrictions on legal capacity on the basis of disability (Martinez-Pujalte, 2019). In 2015, the Irish Parliament signed into law the Assisted Decision Making (Capacity) Act

[2] The author of this article provided support to the CRPD Committee in the drafting and development of General Comment No. 1 on the Right to Equal Recognition Before the Law (Arstein-Kerslake & Flynn, 2016b).

which aims to address the Committee's call for States to provide access to support for the exercise of legal capacity (B. D. Kelly, 2017). Since 2008, when Australia ratified the CRPD, it has initiated several law and policy reform projects at the state level – mostly focused on implementing support for the exercise of legal capacity and emphasising the rights, will, and preference of the individual (Then, Carney, Bigby, & Douglas, 2018). In addition, several other jurisdictions have given significant attention to the issue and are working towards reform (Arstein-Kerslake, 2017; Flynn, Arstein-Kerslake, de Bhailís, & Serra, 2018).

The arguments for maintaining substituted decision-making systems often centre on the rights to life, health, and other forms of protection for the individual. However, it is commonly only disabled people whose rights to legal capacity and autonomy are believed to be subservient to these other rights that are more focused on protection (Arstein-Kerslake, 2017). The balance between autonomy and protection will always be a delicate one. However, the right to legal capacity in Article 12 asks that an individual's autonomy – their recognition as a legal person and agent – is respected on an equal basis for disabled people and non-disabled people (Arstein-Kerslake & Flynn, 2016b; Committee on the Rights of Persons with Disabilities, 2014). This appears difficult, if not impossible, to achieve in substituted decision-making systems in which disabled people are disproportionately denied legal capacity in the name of protection either of themselves or others (Arstein-Kerslake, 2017).

In line with the Committee's definition of legal capacity provided in the General Comment, any time that an individual is not respected as a person before the law or a legal agent, their right to legal capacity may be infringed. This extends beyond guardianship laws and other laws that explicitly remove legal capacity. Legal personhood and agency can also be denied in respect to small decisions and in discrete areas of the law, which may not explicitly be intended to remove legal capacity (Arstein-Kerslake, 2017; Arstein-Kerslake & Flynn, 2017). For this reason, respect for the right to legal capacity requires a holistic examination of laws, policies, and practices that overtly erect barriers to legal personhood or agency as well as those which insidiously do so. For example, when the law criminalises all sexual activity with an individual with intellectual disability, this removes legal agency for sexual choice from individuals with intellectual disability. The intention of such laws may be protection – and they usually do not explicitly deny the legal agency of individuals with intellectual disability. However, their effect is often a denial of legal agency – which is a form of denial of legal capacity, as defined by the CRPD Committee in their General Comment (Arstein-Kerslake & Flynn, 2016b; Committee on the Rights of Persons with Disabilities, 2014). The following sections undertake a holistic examination of law, policy, and practice that either explicitly deny legal personhood or agency or have the effect of doing so for women and disabled women.

3.2. Gendered denials: role of gender in legal capacity denials

This article embraces the CRPD Committee definition of the right to legal capacity and the interpretation that the right to legal capacity is incompatible with substituted decision-making systems, as defined in General Comment No. 1 (Arstein-Kerslake & Flynn, 2016b; Committee on the Rights of Persons with Disabilities, 2014). It uses this definition to examine the history of gendered denials of legal capacity and explore where existing systems continue to deny legal capacity in unique ways to women and disabled women. It then explores how this may be creating vulnerability in various contexts. Finally, it examines the power of autonomy to minimize vulnerability, while also emphasizing the importance of support for the exercise of autonomy.

Historically, gender has been a predicate to full legal personhood and autonomy (Committee on the Rights of Persons with Disabilities, 2016; Matambanadzo, 2012). Until relatively recently in history, women were often considered to be property of their fathers or husbands (Gardner, 1986; Kittell, 1998; Matambanadzo, 2012; Zaher, 2002). They often did not enjoy separate legal personhood from these men, instead the law viewed women as objects and these men held the power to make legal decisions on their behalf (Matambanadzo, 2012). This was a denial of women's legal capacity because their personhood was generally not independently recognised and their legal agency was largely divested to their father or husband.

For example, the practice of coverture dictated that a woman's legal rights and obligations were subsumed by her husband upon marriage – husband and wife became one legal person. The wife was no longer a separate legal person. She had very limited legal rights or obligations separate from her husband. She could not own property, inherit, enter contracts, or keep a wage (Erickson, 2005; Holcombe, 1983; Matambanadzo, 2012; Zaher, 2002). The first major reform of coverture in England came in 1870 with the Married Women's Property Act. The Act came about after significant lobbying and activism by feminist groups (Shammas, 1994; Shanley, 1993). The Act allowed women to keep their own wages and to inherit a certain amount of wealth (Combs, 2005). Shortly thereafter, the Married Women's Property Act of 1882 further secured the right of married women to own, buy, and sell property. It also established married women as separate legal entities from their husbands – it granted legal personhood to wives (Shanley, 1993; United Kingdom, 1882). It is notable that coverture was not significantly reformed in England until the late 19th Century – meaning that women in England have only been guaranteed legal capacity separate from their husbands for less than 150 years (Shanley, 1993).

The coverture laws of England heavily influenced common law countries. Similarly, the Married Women's Property Act in England coincided with a cascade of reforms to coverture laws across common law jurisdictions (Shammas, 1994). However, in the United States the last significant laws related to coverture were not reformed until the 1950s and 60s (Basch, 1986; Flexner & Fitzpatrick, 1996; Matambanadzo, 2012). In California, for example, the 1954 case of *Follansbee v. Benzenberg* was the landmark decision which secured separate legal capacity for women from their husbands. It states, "The legal status of a wife has changed. Her legal personality is no longer merged in that of her husband. Generally a husband and wife have, in the marriage relation, equal rights which should receive equal protection of the law" (Follansbee v. Benzenberg, 1954; Wilson, 1961). As such, women in some parts of the United States have only enjoyed a formal recognition of their legal capacity independent of their husbands for less than 75 years (Vogel, 1990).

Laws such as these were often propagated by the notion that women are objects incapable of reason or self-governance. Women were viewed to need a male counterpart to provide the cognitive capabilities necessary for the exercise of legal capacity (Assassi, 2009; Cheu, 2012; Ward, 2014). While many such laws have been abolished or significantly stripped back, the notion that women are less able to make legal decisions appears to continue to permeate modern legal capacity law. Laws securing the right to exercise legal capacity in the context of reproductive choice for women are continually challenged and remain non-existent or ineffectual in many jurisdictions (Cheu, 2012; Enright et al., 2015; Petchesky, 1990; Smyth, 2002). The ability to exercise legal capacity to consent to sex is frequently framed as a passive permission that the female may grant to a male who is viewed as the decision-maker and holder of power (M. J. Anderson, 2010; Arstein-Kerslake, 2015; Arstein-Kerslake & Flynn, 2016a). There is also evidence that women are denied legal capacity under guardianship regimes at higher rates than men and that they have unique needs under guardianship, which are often unexamined and unmet (Grover, 2002; Rosenberg, 2009; Victoria Office of the Public Advocate, 2017). In these ways and others, women continue to have their legal capacity restricted in ways that men do not experience.

Women and disabled women are experiencing unique barriers to legal capacity due to histories of marginalisation and ongoing prejudice

that perpetuates stereotypes of women and disabled women as inherently vulnerable and lacking in decision-making skills. While many barriers to legal capacity have been reduced, especially for married women, there are many that still exist. Those barriers that remain may be creating situations of vulnerability for these groups.

4. Creating vulnerability: gender, legal capacity barriers, autonomy, and vulnerability

There are some tangible connections between legal capacity denial and the creation of vulnerability in women and disabled women. These contingent vulnerabilities may be leaving women and disabled women at greater risk of abuse (Nosek, Foley, Hughes, & Howland, 2001; Scully, 2013). Other contingent vulnerabilities may be created by the simple existence of laws and policies that insidiously stigmatize women and disabled women by either overlooking their existence completely or assuming a lack of agency and autonomy. In a vicious cycle, such laws and policy can permeate the social conscious and ripple through socio-political relationships and networks to reinforce an often incorrect notion of inherent vulnerability of women and disabled women (Matambanadzo, 2012). In these ways, laws and policies that deny legal capacity and remove autonomy from women and disabled women may be both contributing to contingent vulnerabilities and bolstering historical and erroneous notions of inherent vulnerability.

4.1. Creating vulnerability by denying reproductive and sexual choice of women and disabled women

Reproductive and sexual choice are a poignant example of laws and policies that create vulnerability by denying autonomy to women and disabled women on a differential basis from men. There is a long history of denial of reproductive and sexual choice on the basis of gender. Coverture laws, described above, and other laws that prevented married women from making legal decisions without their husbands were likely applied to issues of reproductive and sexual choice (Cheu, 2012; Petchesky, 1990). Even legal capacity to consent to sexual acts has been removed from married women for centuries through laws that permit rape within the confines of marriage (Hasday, 2000; D. E. H. Russell, 1990). Such denial of legal capacity in the context of reproductive and sexual choices can create vulnerability via psychological disempowerment as well as due to limitations of financial resources and other situations that can lead to dependence.

In addition, rape law itself has a long history of prioritising male autonomy at the expense of female autonomy (M. J. Anderson, 2010; Schulhofer, 1992). For example, as discussed above, the concept of consent is often conceived as a female passively submitting to a male decision-maker, as opposed to an active process of negotiation and agreement between two equal parties (M. J. Anderson, 2010). Rape law has also erroneously ascribed autonomy to women when it is convenient for creating consistency with male choices. For example, when women's clothes and past choices are permitted to be used as evidence that she consented to a man's choices regarding sexual acts (M. J. Anderson, 2002; Lennon, Lennon, & Johnson, 1992; Sterling, 1995). This is not a true granting of autonomy, but instead a masking of the women's choices with the effect of further entrenching the notion that a man's autonomy – his legal capacity – take precedence over a women's in the realm of sexual choice. This creates contingent vulnerability by placing the female in a position of subservience to the male – making her vulnerable to the choices of the male.

4.1.1. Disabled women and sexual choice

Sexual choice is also frequently denied to disabled women, particularly those with cognitive disability – including mental health disability, intellectual disability, dementia and others (Arstein-Kerslake, 2015; Waxman, 1994). In some jurisdictions, there are laws that criminalise all sexual activity with intellectually disabled women (Arstein-Kerslake & Flynn, 2016a; Brendan D. Kelly, 2014). Disabled women are also often prevented from exercising legal capacity to consent to sex through policies or informal arrangements that discourage sexual relationships. For example, there is significant evidence that disabled women and girls often have limited access to sex education, which would facilitate the meaningful and informed exercise of legal capacity to consent to sex (Dukes & McGuire, 2009; Eastgate, van Driel, Lennox, & Scheermeyer, 2011; Esmail, Darry, Walter, & Knupp, 2010; McCarthy & Thompson, 1997; Tepper, 2000). In addition, there is evidence that some residential service providers for disabled people discourage romantic and sexual relationships and may even act to prevent sexual relationships (Cuskelly & Bryde, 2004; Esmail et al., 2010; Brendan D. Kelly, 2014).

This denial of the freedom to exercise legal capacity to consent to sex for disabled women creates contingent vulnerability. It often leaves disabled women without the tools necessary to exercise legal capacity to consent to sex because when they are restricted from doing so, they often do not have the opportunity to develop the skills necessary for exercising choice related to sexual activity (Dukes & McGuire, 2009). (Decision-making is well-documented as largely a learned-skill in all people which requires education, training, and repeated experience in order to develop and grow (Byrnes, 2013). This is true for all decision-making, including sexual decision-making (Dukes & McGuire, 2009; Juhasz, 1975).) For example, when faced with a situation of sexual abuse, an individual may not be able to identify or distinguish it as abuse if they were not previously exposed to sexual choices in an appropriate sexual relationship. This is a significant risk and there is a growing body of evidence to indicate that many disabled women experience this (Eastgate et al., 2011; McCarthy & Thompson, 1997).

Furthermore, if legal capacity to make sexual choices is largely denied to disabled women, it is likely that safeguards and infrastructure for supporting disabled women in making such choices is not available. This creates contingent vulnerability because disabled women are left without critical support for making sexual choices and may, thereby, be left without avenues for recourse when sexual abuse occurs. There is likely multiple other ways that contingent vulnerability may be created by the denial of legal capacity to exercise sexual choice – this is merely the beginning of the discussion to highlight the multitude of opportunities for vulnerability to bubble up and the potential ineffectiveness of denying legal capacity to sexual choice as a means of protection.

4.1.2. Abortion

Reproductive choice is also denied to women through the criminalisation of abortion. Biologically, men are not able to get pregnant and are therefore not subjected to laws that do not permit reproductive choice in the form of abortion. However, due to historical and ongoing paternalism and the socio-political power that men hold, if men were able to get pregnant they may not be subjected to the denial of their autonomy – the denial of their legal capacity – to make decisions regarding reproductive choice, such as abortion (Kleinman, Copp, & Sandstrom, 2006; Kumar, Hessini, & Mitchell, 2009; Shalev, 2000; Steinem, 1978). This is evidenced by the long history of laws, described above, that remove autonomy from women disproportionately to that of men. This includes abortion laws which continue to restrict women's exercise of their legal capacity to make reproductive choices. For example: laws that restrict abortion to only certain circumstances, such as when the health of the mother is at risk or where there is evidence of incest or a sexual assault; policies that exclude abortion from health care insurance cover – making it prohibitively expensive and consequentially removing it as a possible choice for many women; and a lack of measures to ensure that clinics where abortions are performed are safe and accessible environments for women (Finer & Fine, 2013; P. B. Levine, Trainor, & Zimmerman, 1996; Shah, Åhman, & Ortayli, 2014; Siegel, 2007; Zampas & Gher, 2008). There is not space in this article to provide a full debate on where the right to legal capacity to reproductive choice should begin and end in the context of abortion.

However, the lack of widespread availability of abortion and the ongoing overbroad restrictions on abortion in law and policy amount, at a minimum, to denial of the right to legal capacity to reproductive choice for women.

The denial of legal capacity for reproductive choice in the context of abortion leads to contingent vulnerability in multiple ways. When a woman is faced with an unwanted pregnancy, she loses bodily autonomy which often precipitates social and psychological disempowerment (Schmiege & Russo, 2005; Silverman, Gupta, Decker, Kapur, & Raj, 2007; Sloane, 1969). Such disempowerment can ultimately lead to vulnerability to interpersonal abuse – financial, emotional, or physical in nature (Goodwin, Gazmararian, Johnson, Gilbert, & Saltzman, 2000; Pallitto, Campbell, & O'Campo, 2005; Silverman et al., 2007). Unwanted pregnancies can also often lead to an increased financial burden that arises with the care of a child or multiple children. Sometimes a woman is unable to bear this burden on her own – particularly in light of the ongoing pay gap between men and women and high unemployment rates that women experience in many countries (Francine D. Blau & Kahn, 2003, Blau & Kahn, 2007; Azmat, Güell, & Manning, 2006). This burden can then lead to a dependence on others, particularly men, for financial support. This dependence can also create contingent vulnerability to interpersonal abuse – financial, emotional, or physical in nature (Brandwein, 1999; Conner, 2013; Kaukinen, 2004).

4.1.3. Forced sterilisation and contraception

Legal capacity to exercise reproductive choice is also denied to women in the form of forced sterilisation. This occurs particularly in the context of disabled women and girls. There are laws in some jurisdictions that allow for the forced sterilisation of disabled women and girls (Cepko, 1993; Patel, 2017; Pham & Lerner, 2001). In addition, some disabled women are only offered methods of contraception that may jeopardise their reproductive health (Waxman, 1994). There is also evidence that sterilisations are performed at the request of family members or others, without attention paid to the will or preference of the disabled woman or girl (Rosenbaum & Epstein, 2019). For example, the *Mental Capacity Act* 2005 in England and Wales has permitted sterilisations based on the 'best interests' of the woman or girl, as opposed to her will or preference (Jordane Watson, 2015). Both contexts of forced sterilisation result in a denial of the individual's legal capacity to choose sterilisation, as well as in her legal capacity to make reproductive choices for the remainder of her life.

The denial of legal capacity to choose whether to undergo sterilisation can lead to contingent vulnerability in multiple ways. One of the most profound ways may be the loss of bodily integrity that a woman may experience when she is sterilised without her consent. This can have a significant effect on self-esteem and psycho-social perceptions of oneself (Rosenbaum & Epstein, 2019). In addition, sexual abuse of disabled women and girls often occurs within the home (Mays, 2006; McFarlane et al., 2001). It is also often family members that are given either formal or informal power to decide whether a disabled woman or girl will undergo sterilisation (Rosenbaum & Epstein, 2019). As such, it could be an abuser who is granted the legal capacity to decide that the disabled woman or girl will undergo sterilisation. The disabled woman or girl could then be vulnerable to new or increased sexual abuse perpetrated by the family member or others within the home with the knowledge that there will be no reproductive consequences of the sexual abuse. There are likely many other vulnerabilities created by denials of legal capacity to make sterilisation decisions. More research is needed in this area in order to fully understand all the manners in which vulnerability may be created by forced sterilisation and how to prevent and address them.

There are likely many other forms of vulnerability that are created by the denial of legal capacity to women and disabled women in the context of reproductive and sexual choices. More research in this area is needed to fully understand how and where this vulnerability is being created. Such research could inform the development of law, policy, and practice that better protects the right to legal capacity to make reproductive and sexual choices and better accounts for the contingent vulnerability that is created when the right is not respected – it may even be able to eliminate such vulnerability.

4.2. Creating vulnerability in women and disabled women under guardianship with limited decision-making control over their own lives

Guardianship, and other forms of interdiction and conservatorship, are one of the most complete forms of legal capacity denial. It occurs when the law provides a mechanism for the removal of legal capacity in relation to one or more decision. The most all-encompassing form is plenary guardianship, where an individual's legal capacity can be completely removed and ascribed to another individual or group of people – for example, a family member, a group home or institution, or a court. There are also more limited forms which include either limited guardianship or laws, such as the *Mental Capacity Act 2005* in England and Wales, which allow for the removal of legal capacity in regard to either a specific decision or a specified area of life (Arstein-Kerslake, 2017; Flynn & Arstein-Kerslake, 2014; Series, 2013).

There is evidence that women experience guardianship uniquely (Grover, 2002; Rosenberg, 2009; Victoria Office of the Public Advocate, 2017). There is also evidence that women may be disproportionately placed under guardianship – potentially, due to the lasting impacts of historical notions of women as less rational and in more need of protection than men (Prokhovnik, 2012; Rosenberg, 2009; Tavris, 1993; Victoria Office of the Public Advocate, 2017). For example, until recently, it was widely accepted that women with intellectual disability living under guardianship in institutional settings would almost automatically be given either medication to end their menstrual cycle or would undergo surgery for sterilisation or some form of management of their menstrual cycle. This was often done in the 'best interests' of the individual – the individual or entity that maintained guardianship, or was ascribed her legal capacity in another form, made the decision based on what they believed to be in the woman's best interest (Grover, 2002). While, in many places, this policy has changed in institutional settings (Atkinson et al., 2003), young women under guardianship and other substituted decision-making regimes are still faced with menstrual and sterilisation decisions that are made on their behalf, in their 'best interests' (Atkinson et al., 2003; Grover, 2002; Lin, Lin, Chu, & Chen, 2011; Wingfield et al., 1994; Wingfield, Healy, & Nicholson, 1994).

In addition to the loss of reproductive choice, the loss of legal capacity under guardianship or other forms of substituted decision-making is often also accompanied by loss of financial control – the substituted decision-maker can be given control over financial decisions for the individual. Loss of financial control can create contingent vulnerability because the individual loses the power and resources that accompany financial control. There is significant evidence that financial abuse under guardianship is common and often accompanied by few safeguards or avenues for recourse for the individual experiencing abuse (Bond, Cuddy, Dixon, Duncan, & Smith, 2000; Coker & Little, 1997; Dessin, 2002; Wilber & Reynolds, 1996). There is also evidence that women experience such financial abuse at higher rates than men (Bond et al., 2000).

4.3. Creating vulnerability through forced psychiatric treatment of women and disabled women

Forced psychiatric treatment of women has a long history tied to the misperception of women as 'hysterical' and suffering from madness. While psychiatry has been deeply criticised by some of the leading scholars of our time (Erving Goffman, Michel Foucault, and others), most scholars overlooked the role that gender played in psychiatry until second-wave feminists identified it in the 1970s (Foucault & Howard,

2001; Goffman, 2017; Hubert, 2002; Sedgwick, 1982). For example, Phyllis Chesler's book *Women and Madness* and Elaine Showalter's book *The Female Malady* identified these gendered practices within psychiatry and the gendered nature of the concept of 'madness' itself (Chesler, 1974; Hubert, 2002; Showalter, 1987). While psychiatry has evolved significantly, woman continue to experience both internalised oppression from these early emanations of psychiatry as well as systemic and socially imposed oppression (Hubert, 2002).

Rates of psychiatric disorder are virtually the same for men and women, however there are significant differences in how women are diagnosed and treated (Kessler et al., 1994). Women remain the majority of psychiatric patients (Katherine Hodges, 2003). Women are more likely to be treated with psychotropic drugs and are more likely to be diagnosed with depression and anxiety (Linzer et al., 1996; Piccinelli & Gomez Homen, 1997; Simoni-Wastila, 2000). Stereotypically female traits are also more likely to be regarded as indications of mental health issues. For example, expression of emotions, deference to others, lack of assertiveness, and others (D. Russell, 1987). In this way, women who are performing in accordance with gender stereotypes are at risk of being diagnosed as mentally unwell. However, women who are performing outside their gender role may also be at risk of being diagnosed as mentally unwell because they are straying from societal expectations for females (D. Russell, 1985). As women are more likely to be involved in the psychiatric treatment systems, it follows that they are disproportionately at risk for being denied legal capacity within these systems and forcibly treated or detained. A recent study has noted how little research exists in this area and how much more needs to be done to accurately understand the needs of women in psychiatric care (Archer, Lau, & Sethi, 2016).

The contingent vulnerability that is produced from these gendered perspectives and practices in psychiatry is pervasive. Within the psychiatric system, there is evidence that women are vulnerable to sexual and physical abuse due to systems that are ill-suited to the needs of women (Archer et al., 2016; Mental Health Complaints Commissioner, 2018). More generally, the on-going notion that women are over-emotional and prone to irrationality – including extremes of panic and anxiety – undermines women as decision-makers and leaders. It may contribute to the ever-persistent pay gap between men and woman as well as the lack of women in political leadership roles which remains in most countries. Employment, financial resources, and political leadership are all areas of significant social capital that women are currently missing out on. While it is not only the psychiatric systems that may be creating and contributing to this problem, the gendered aspects of the psychiatric system – including the ever-present reality that the labelling of a psychiatric diagnosis could result in the removal of legal capacity and an experience of forced detention or treatment – are likely contributing to these negative social phenomena that women are experiencing.

5. Conclusion

Women and disabled women are often inaccurately perceived as inherently vulnerable due to long histories of prejudice and marginalisation. While some women and disabled women do experience some forms of inherent vulnerability due to biological factors such as physical strength or chronic pain, most of the vulnerability that they experience is contingent on social phenomena. The perception that women and disabled women are inherently vulnerable can perpetuate the discrimination that these groups face by supporting the instigation of law, policy, and practice that denies autonomy to these groups either under the guise of protection or simply due to historical stigma or notions regarding the inability of these groups to possess sufficient decision-making skills.

Women and disabled women face barriers to legal capacity, in part, due to their perceived inherent vulnerability. These unique legal capacity barriers that women and disabled women experience further create contingent vulnerability in various ways, discussed above. Law, policy, and practice has not sufficiently examined or accounted for these issues. More research in these areas is needed. In order to achieve equal recognition before the law for these groups, it will require more than a neo-liberal removal of barriers to legal capacity and abandonment of these individuals. Instead, it will require a reassessment of where vulnerability has been created by these legal capacity denials and what forms of support are necessary for the meaningful return of that autonomy and the successful exercise of legal capacity for members of these groups. This, in turn, will likely reduce vulnerability in these groups – at least the vulnerabilities that were contingent on the denials of autonomy that they faced.

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