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The role of defensive functioning in positive deviance in psychological wellbeing amongst young women living in Soweto, South Africa

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ABSTRACT

This qualitative study explored how mature defence mechanisms support positive deviance in health and wellbeing among young women facing adversity in Soweto, South Africa. Drawing from the *Bukhali* randomized controlled trial in Soweto, which targets improved health trajectories for young women, this study focused on a group of participants who exhibited positive deviance in the trial by being employed or studying, engaging actively in the trial, and showing favourable physical and mental health indicators despite living in a context marked by poverty, inequality, and trauma. Eight in-depth interviews were conducted with participants who met selection criteria, and data were analysed using a codebook thematic approach, incorporating a psychoanalytic framework of defensive functioning. Participants demonstrated frequent use of high adaptive defences, such as anticipation, self-observation, sublimation, and self-assertion, which enabled emotional regulation, agency, and healthy coping. Self-isolation and low affiliation, often seen as withdrawal, were reframed as protective strategies when balanced with meaningful social connections. These findings offer a psychologically rich understanding of how young women in challenging environments navigate complex social landscapes. By integrating positive deviance with defensive functioning, the study extends psychoanalytic theory to marginalized contexts, revealing how mature defence mechanisms contribute to resilience. The insights have implications for designing strength-based mental health interventions tailored to the realities and psychological capacities of marginalized populations.

1. Introduction

Defensive functioning is a central aspect of personality development, with its maturity playing a key role in how individuals navigate and overcome adversity. The psychodynamic concept of defence mechanisms refers to automatic psychological processes that individuals use to manage emotional conflicts and cope with internal or external stressors (American Psychiatric Association and DSM-5 Task American Psychiatric Association, DSM-5 Task Force, 2013; Perry, 2014). The adaptive value of these mechanisms derives from their function of regulating affect, preserving self-coherence, and maintaining relationships in the face of stress. Mature defences, such as sublimation, humour, and suppression, enable individuals to tolerate ambiguity, manage impulses, and sustain adaptive functioning under pressure. In contrast, immature or maladaptive defences, such as projection, denial, or splitting, may distort reality, contribute to interpersonal difficulties, and maintain psychopathology.

Extensive empirical work has demonstrated that higher levels of defensive maturity are associated with greater psychological well-being, more coherent personality organization, and better interpersonal functioning (Cramer, 1987, 2015; Perry, 2014; Vaillant, 1994). Defensive functioning is also predictive of treatment outcomes across psychotherapeutic modalities, as individuals who employ more adaptive defences tend to engage more effectively in therapy, exhibit greater emotional insight, and achieve more sustained symptom reduction (Hoffman, 2016; Kramer et al., 2013; Perry and Henry, 2004). In this

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sense, the development and maturation of defensive functioning can be understood as a critical mechanism underpinning resilience, emotional regulation, and overall mental health. However, the expression and development of defensive functioning do not occur in isolation; they are shaped by social, cultural, and structural conditions that influence the kinds of stressors individuals face and the psychological resources available to them).

Young women living in Soweto, a densely populated, low-income urban area of Johannesburg, face intersecting structural and social challenges. These include systemic inequality, gender-based violence, trauma exposure, economic hardship, limited access to education and employment, and food insecurity, all of which have serious implications for physical and mental health (Draper et al., 2019, 2022, Draper et al., 2023, Redinger et al., 2018; Ware et al., 2019, 2021). Despite these realities, little is known about how psychological mechanisms, such as defensive functioning, operate within this context. Although existing South African research has begun to explore defensive functioning (Coetzee and Cilliers, 2012; Cilliers and May 2010; Auld and Cartwright, 2018; Mnguni, 2012), this work remains largely confined to formal organizational and academic spaces.

1.1. Positive deviance

Positive deviants are individuals who often adopt distinctive practices or behaviours that yield more favourable outcomes (Pascale et al., 2010). Although the concept has its theoretical roots in sociology (Herington and Van De Fliert, 2018), and initially gained prominence in the field of nutrition, describing healthy children in contexts of widespread malnutrition, it has since evolved into a broader framework that identifies individuals or groups who achieve success under the same conditions that challenge their peers (Positive Deviance Collaborative, 2017). A positive deviance approach shifts focus from deficits to capabilities, acknowledging the agency, resourcefulness, and resilience of individuals within their social contexts (Marsh et al., 2004; Positive Deviance Collaborative, 2017).

A positive deviance approach has been applied across a range of disciplines in South Africa, from child nutrition (Pilditch et al., 2024), to healthcare adherence (Ober et al., 2025), early learning outcomes (Henry and Giese, 2023), and entrepreneurship in low-income contexts (Du Toit et al., 2020). These studies demonstrate its utility in identifying and understanding adaptive practices that defy systemic limitations. This approach offers a valuable and complementary framework for understanding how certain young women in low-income South African settings are able to achieve favourable outcomes despite facing significant structural and environmental constraints. These women may demonstrate exceptional outcomes not because they have access to greater resources, but because they adopt uncommon strategies or mindsets that enable them to thrive where others struggle. This approach enriches the perspective of defensive functioning by capturing both the internal mechanisms and observable behaviours through which resilience is expressed and sustained in marginalized settings.

In this context, to define thriving and resilience, we draw on the concept of *ukuphumelela* (flourishing) that has been previously been used in research conducted in Soweto (Cele et al., 2021; Draper et al., 2025). *Ukuphumelela* encompasses structural, social and cultural factors that influence individuals' ability to flourish, and implies that individuals are successful in their efforts to achieve something, despite the challenges they face (Cele et al., 2021). Resilience in this context refers to these individuals' adaption to these challenges, at mental, emotional, and behaviour levels (VandenBos, 2007).

1.2. Healthy life trajectories initiative

HeLTI is an international consortium developed in partnership with the World Health Organization (WHO) in Canada, India, China, and South Africa. For HeLTI SA, the *Bukhali* randomized controlled trial is being conducted with 18–28-year-old women in Soweto (Norris et al., 2022). HeLTI hypothesizes that an integrated, life-course intervention can improve both physical and mental health, establishing healthier trajectories for young women and future generations. The *Bukhali* complex intervention (Draper et al., 2023) spans the life-course stages of preconception, pregnancy, infancy, and early childhood, and each life-course stage has specifically developed intervention materials. The intervention is delivered by trained community health workers (referred to as 'Health Helpers'), and it provides health literacy support (physical and mental health issues relevant for young women), risk screening (obesity, anaemia, depression, anxiety, diabetes, hypertension), multi-micronutrient supplementation, and health behaviour (e.g. physical activity, dietary behaviour, sleep, screen time) change through Healthy Conversation Skills (Barker et al., 2011; Lawrence et al., 2016).

Extensive qualitative work has been conducted as part of the *Bukhali* trial process evaluation to characterize the contextual realities and lived experiences of both the trial participants and Health Helpers, including the structural and social challenges mentioned earlier (Draper et al., 2025; Draper et al., 2020, 2022, Draper et al., 2023, 2024, 2025a, 2025b; Mabetha et al., 2024a, 2024b, 2024c, Soepnel et al., 2024a, 2024b). Building on this work, positive deviance offers a lens for understanding how some trial participants, despite their adversity, not only survived but thrived. This asset-based approach highlights strengths and innovative strategies, shifting focus from vulnerability to empowerment. Incorporating defensive functioning theory further enriches this perspective, and together, these frameworks offer a comprehensive view of resilience, combining both practical strategies and internal psychological processes. This combination of approaches is novel, since the dual framework of positive deviance and defensive functioning has not previously been investigated in other South African contexts, nor are there published studies from other countries.

The aim of this study was to apply these frameworks to participants within the *Bukhali* trial, in order to uncover the psychological strategies that enable young women to thrive despite adversity, and to understand how they engage with the *Bukhali* trial.

2. Methods

2.1. Participants and recruitment

This qualitative, exploratory study used individual, semi-structured in-depth interviews to generate data from *Bukhali* trial participants in the intervention arm, specifically those who were enrolled or had recently completed the preconception phase of the intervention at the time of the interview. In the context of the *Bukhali* trial, participants were classified as positive deviants if they were: 1) actively engaged in the trial (not considered hard to reach), 2) employed, or in education or training (at time of recruitment), and 3) scored in the normal range for the majority of their health indicators (blood pressure, body mass index, blood sugar, iron, depression, anxiety, knows HIV status).

At the time of recruitment, 13 participants met the criteria mentioned above, and were contacted telephonically to see if they were willing to be interviewed. Only one participant was not interested in being interviewed, and of the 12 who were willing, interviews could not be scheduled for three participants due to conflicting commitments (e.g. exams, work). One participant arrived for her interview, but got called away for a family emergency shortly after starting the interview, and it was not possible to reschedule. Interviews were hence conducted with eight participants between 19 and 27 years old; five of them had a child (prior to enrolling in the trial). Two of the participants had already exited the preconception phase of the trial (i.e. did not become pregnant), and six were enrolled in the trial at the time of the interviews.

2.2. Procedure

Eight interviews were conducted in November 2023 at the research

site. The interviews ranged between 70 and 108 min (average length 94 min). Transport costs were reimbursed for participants. Interviews were facilitated by NT, with NN present as notetaker. The interview guides were developed collaboratively amongst co-authors (CD, NT, NN, SN; included as supplementary material), drawing on salient issues that had emerged in previous work with the *Bukhali* trial, and engagement with the trial staff. While these were developed in English, facilitators were able to converse with participants in English or in local languages, when necessary, as is typical in the multi-lingual context of Soweto. The discussions were audio recorded, transcribed verbatim, and translated into English.

2.3. Data analysis

The analysis process began with two of the authors (CD, CH) reading the interview transcripts to obtain initial impressions of how positive deviance could be characterized and understood in this sample. Both authors have a background in psychology (CD in research psychology, and CH in community-based counselling psychology) and have experience in conducting research in the Soweto context (including on mental health), with a heightened awareness of the challenging lived experiences of women in this context. From their initial reading of the transcripts, both authors agreed that positive deviance was not a result of these participants experiencing fewer challenges, or that their life circumstances were lacking in adversity. Rather, there appeared to be underlying psychological reasons for these women to be thriving in the context of adversity. Defensive functioning was agreed to be an appropriate psychological framework for understanding positive deviance in this sample, since the participants appeared to be exhibiting more mature defence mechanisms according to the DSM (American Psychiatric Association, 1994; American Psychiatric Association and DSM-5 Task American Psychiatric AssociationDSM-5 Task Force, 2013; Perry, 2014; Vaillant, 1977, 1971).

For the next steps in data analysis, a codebook thematic approach was taken (Braun and Clarke, 2019, 2021, 2023). Our approach aligned more with a general conceptualisation of Braun and Clarke's argument that codebook thematic analysis balances a structured coding approach with a qualitative and non-positivist paradigm, still allowing the exploratory, flexible and iterative nature of reflexive thematic analysis. Furthermore, this approach accommodates our subjectivity and acknowledges that a 'correct' interpretation of data is not possible.

Using the generally accepted hierarchy of defence levels and mechanisms (American Psychiatric Association, 1994; American Psychiatric Association and DSM-5 Task American Psychiatric AssociationDSM-5 Task Force, 2013; Perry, 2014; Vaillant, 1977, 1971), and summarized in Table 1, a coding framework was developed, which also included codes for other contextual information about participants, and their experiences of the *Bukhali* trial. Additional codes were added to the framework when other trends became evident in the data, and were not captured by the defence mechanisms, but still provided insights into how participants characterized themselves. The coding framework was then applied to the transcripts to identify relevant portions of the text that corresponded to these codes using MAXQDA data analysis software. This was initially done by CD, and then by CH; differences in coding were discussed to reach consensus. Coded sections were then exported and summarized, and illustrative quotes were selected and are presented in the results section.

It is important to note that the interviews were not initially intended to elicit defence mechanisms, but transcripts were examined to look for evidence of defence mechanisms. These defence mechanisms were not directly observed in participants, and we do not have another source of data as evidence of defence mechanisms other than the interview transcripts. Therefore, when reporting on the results, the terms 'exhibit' or 'display' are used in relation to participants using defence mechanisms, this is referring to participants' responses in the interviews.

Table 1
Defensive levels and defence mechanisms.

Defensive Level	Defence mechanism	Definition
High adaptive level	Anticipation	The ability to anticipate a potentially stressful or difficult situation and plan in advance for how to cope with it.
	Affiliation	Seeking out the company of others to share one's feelings, especially during times of stress or emotional discomfort.
	Altruism	Deriving personal satisfaction from helping others, often to cope with personal anxiety or distress.
	Humour	Using humour to cope with difficult situations, including the ability to laugh at oneself and find the lighter side of challenging circumstances.
	Self-assertion	Standing up for oneself and expressing needs or rights in a healthy, non-aggressive way.
	Self-observation	The capacity to reflect on one's own behaviours, emotions, and thoughts, and understand one's role in a given situation.
	Sublimation	Channelling unacceptable or distressing emotions, thoughts, or urges into positive, socially acceptable activities like art, exercise, or creative work.
	Suppression	The conscious act of pushing unpleasant thoughts or feelings out of awareness temporarily, in order to focus on other matters or avoid distress.
Mental inhibition level	Displacement	Redirecting strong emotions or impulses from the original target to a safer, less threatening object or person.
	Dissociation	A disconnection from the present moment, such that the individual may feel detached from reality or their own experiences.
	Intellectualization	Focusing on abstract or rational thoughts and explanations to avoid confronting emotional content or feelings associated with a situation.
	Isolation of affect	Separating emotions from thoughts in order to avoid experiencing the emotional response to a particular event or memory.
	Reaction formation	Adopting attitudes, behaviours, or beliefs that are the opposite of one's true feelings, often to hide or deny undesirable thoughts or impulses.
	Repression	Unconsciously blocking out unpleasant memories, thoughts, or feelings from awareness because they are too painful or anxiety-provoking.
	Undoing	Attempting to "reverse" or "undo" an unacceptable thought, action, or feeling by engaging in opposite behaviour, often as a way of alleviating guilt or anxiety.
Minor image-distorting	Devaluation (other)	Attributing overly negative qualities to others, often to protect oneself from feelings of inferiority or inadequacy.
	Devaluation (self)	Viewing oneself as worthless or inadequate, often in response to feeling rejected or inferior.
	Idealization	Overvaluing another person, often to an unrealistic degree, to maintain a sense of security or admiration, while ignoring their faults or flaws.

(*continued on next page*)

Table 1 (*continued*)

Defensive Level	Defence mechanism	Definition
	Omnipotence	The belief in one's own unlimited power or abilities, often as a way to cope with feelings of helplessness or insecurity.
Disavowal level	Denial	Refusing to accept the reality of an unpleasant situation or fact, thereby blocking out the emotional impact of the event.
	Projection	Attributing one's own undesirable thoughts, feelings, or impulses onto someone else, as a way of defending against anxiety or guilt.
	Rationalization	Justifying or explaining undesirable behaviours, thoughts, or outcomes with logical reasons to avoid facing the real reasons.
Major image-distorting	Autistic fantasy	Retreating into an inner world of fantasy or daydreams, often as a way to escape from unpleasant or unmanageable feelings or circumstances.
	Projective identification	A form of projection where the individual not only attributes their own feelings or impulses to others, but also manipulates others to act in ways that confirm the projection.
	Splitting of self-image or image of others	Viewing oneself or others in all-or-nothing terms, either as all good or all bad, often as a way to manage conflicting emotions or perceptions.
Action level	Acting out	Engaging in impulsive or inappropriate behaviour to express emotions or resolve conflicts, rather than reflecting on or processing them in a more controlled manner.
	Apathetic withdrawal	Withdrawing emotionally or physically from a situation, typically in response to frustration, sadness, or conflict, as a form of avoidance.
	Help-rejecting complaining	Persistently complaining about problems while rejecting or disregarding offers of help or solutions, often as a way of avoiding responsibility or change.
	Passive aggression	Indirectly expressing hostility through procrastination, stubbornness, or sulking, rather than addressing the issue directly.

2.4. Ethical considerations

Ethical approval for this study was obtained from the Human Research Ethics Committee (Medical) at the University of the Witwatersrand (M190449). All methods were carried out in accordance with relevant guidelines and regulations; all participants gave written informed consent for their involvement in the study. The authors assert that all procedures contributing to this work comply with the ethical standards of the relevant national and institutional committees on human experimentation and with the Helsinki Declaration of 1975, as revised in 2008.

2.5. Reflexivity

We acknowledge that our training, roles, lived experiences, identities, and values have influenced the research process. Positionality statements for all authors are included in the supplementary material.

3. Results

The presentation of findings begins with participants' characterizations of their life circumstances, to provide a contextual background to the application of the defensive functioning lens. The two sections that follow discuss the most common and less common defence mechanisms identified through the data analysis, and the last section addresses how participants make sense of themselves.

3.1. Participants' life circumstances

Participants described the community in which they reside (within Soweto) as challenging, with prevalent issues such as substance abuse, gender-based violence (rape, intimate partner violence), crime, teenage pregnancy, and low educational attainment. When asked about strengths of their community, five participants felt strongly that their community had no strengths and did not support them or contribute to their success. The other three participants mentioned community resources such as programs at a local community centre (although these are not financially accessible to all) and the availability of fresh fruit and vegetables available from local vendors (in relation to healthy eating).

> *There is not even an organization that teaches children to take care of themselves, don't do this, do that, the dangers of this are that, there is no such thing, the parents don't care, so no. (Busi)*

> *I do not think there is anything in my community, there is nothing that can encourage me. [Why?] Because people are just living. [What do you mean?] They do not care about anything, they are just living. If it is someone who is working, they wake up in the morning go to work and come back and just sit at home. They will just be looking at people passing by in the streets. (Ayanda)*

Participants gave varying accounts of their life circumstances, which help to contextualize the findings with respect to defensive functioning of these participants. Overall, socioeconomic challenges were a feature of all participants' stories, and experiences of loss and trauma were common. Table 2 provides a brief summary of each participant's account, using the present tense to depict their situation at the time of the interview.

3.2. Most common defence mechanisms

The most common defence mechanisms exhibited by all participants were at the high adaptive level, particularly self-observation and self-assertion. Other mechanisms at this level were also common, but not with all participants.

3.2.1. Self-observation

All participants showed the capacity to reflect on their emotions, thoughts and behaviours, and an awareness of their role in the situations they described. Many participants specifically spoke about self-awareness and self-confidence, and self-acceptance was frequently mentioned. An increased awareness of self-care was linked to them gaining new knowledge about health and health behaviours as part of the trial.

> *It is, you have to know about yourself, and not care what people say about you, you see, you have to love yourself before you love someone else. (Neo)*

> *When you have self-confidence, it means you are aware of yourself, and you can do anything. [And self-acceptance?] Accepting yourself and situation you're in. (Lebo)*

> *I think there are things that I am doing because now I have knowledge, so I am preventing myself from those things, alcohol abuse and pregnancy, and I know that when I am pregnant, I will have to take vitamins and whatnot, basically, I learnt a lot of things about health here. (Anele)*

While some participants were better at articulating their understanding of health than others, all of them saw health as both physical and mental.

Table 2
Participants' life circumstances.

Participant pseudonym	Brief biography	Historical circumstances/ stressors	Current circumstances/ stressors
1. Neo	Completing matric (high school qualification) at an adult education establishment. Lives with her 6-year-old child and aunts.	Her mother passed away when she was 8 years old. Became pregnant when she was at high school and left school.	Aunts are a good source of social support and stability, and are positive role models in her life. Estranged from her father. Relationships with her siblings are "not alright".
2. Ayanda	Currently working and receiving a stipend. Staying with her grandmother and brother.	Father was absent. Left with family members in a rural area when her mother went to Johannesburg to work. Family members were abusive to her, and she eventually left to live with her mother and uncle.	Studied after finishing school but struggled with completing her studies. Her mother is supportive of her, even though she remarried and has other children that her stepfather prioritises over her mother's older children.
3. Khanya	Currently unemployed. Has a 5-year-old child	Lost her mother when she was 10 years old, regarded her highly. Her father was absent and changed after her mother died, with numerous women that she was expected to see as a replacement mother.	Does not have a good relationship with her stepmother. Describes her father as mean, uncaring and emotionally abusive. Has little to do with her extended family on her mother's side, but has an elderly lady in her street that is supportive (in contrast to her family).
4. Lebo	Self-employed as a hairdresser.	Grew up with both parents having substance abuse issues. Her father left when she was young, and she had to look after siblings. Her mother was unemployed and struggled to provide for her; her mother was strict, but she saw this as a positive influence.	Describes relationship with her mother as good, and sees her as supportive.
5. Anele	Lives with her parents (mother and stepfather) and siblings, and has a 2-year-old child. Currently unemployed.	Growing up, she had to look after her siblings while her mother worked. Her mother and father split up and both remarried, and she feels her mother and stepfather prioritise their young children. Relationship with her mother has been conflictual, and things got worse after she became pregnant when she was at college.	Hoping to have more training opportunities to build on the training she recently completed. Her mother is supportive in other ways, such as with healthy eating habits.
6. Busi	Currently unemployed.	Raised by her mother. Her father was absent for her upbringing but is still in her life. Has a conflictual relationship with her father, and she describes him as emotionally abusive and not at all supportive. Had a serious illness during childhood, and her mother had to take time off work and lost her job.	Keen to study law. Has a good relationship with her mother, and feels she is supportive.
7. Lindiwe	Married to the father of her first child. Lives with her two children and her cousin's child. Not employed, reliant on husband's income.	Raised by her single mother since her father died when she was 5 years old. Had to drop out of school to care for her sick mother (after her sister died) and look after her siblings. Received little support from her extended family when her mother died; some blamed her for their deaths. Was raped multiple times, including by her uncle with whom she lived as an adolescent. Became pregnant at school, and after she suffered postnatal depression, the child's father took the baby away from her when she harmed the child. Became pregnant again with another boyfriend, who was abusive, but eventually got back together with the father of her first child.	Husband described as her sole source of social support,
8. Thato	Has a 3-year-old child, Works a weekend job.	Her father died when she was 3 years old, was raised by her mother. Her mother did not work, but managed to provide for them and was astute at managing her finances to meet her children's needs.	Father of her child is supportive, but he does not live with them. Plays the main caregiving role for her ill mother, more so than her brother and sister.

Health is having a fit body with a stable mind. (Khanya)

Related to this, they spoke about making positive decisions and choices, taking responsibility, knowing their values ("what kind of

person I must be"), setting goals, and being motivated. In terms of their motivations, some specifically said they want to change things for their own child (considering their past experiences), whereas others felt like they were just living to survive.

It is alright, because I know what is going on with me and how I must treat myself, no matter what I have, but I know what kind of person I must be. (Neo)

I guess when I sat down and did some self-introspection. I realize that taking my life and doing all those crazy things would not help at all because as long as I can still wake up, there is still life to be lived. I had to do better and see where I would end up. (Ayanda)

All participants portrayed themselves as independent, and valued independence as a trait, along with resilience and patience, which they often linked. One participant described resilience in terms of connection and commitment.

To be resilient, I can say that it influences as well, no, to be resilient is part of your journey, when you set up goals and then you don't achieve them, you have to go and try again, so I can say being resilient, for me, it's that. [… what does resilience mean?] I can say, for them, it is to be connected, to be connected to something … like education, to learn, along the way, there might be some challenges and being able to overcome those challenges, trying again, and going on, because you want that certificate or degree, whether there are challenges or not, but it is to be committed. (Anele)

Participants could also articulate their role in achieving success and stability in different parts of their life (education, finances, health), although this was usually discussed in the context of their socioeconomic circumstances.

Being successful according to my understanding it is not about having a lot of money, you can have a lot of money but not successful. I feel like success is when you are able to manage yourself firstly, to love and afford yourself … For me as a woman if I can pay for my rent, buy food and toiletries, if I can be able to travel to wherever I want to go that will be success for me. (Ayanda)

I can tell success once I start working, when I can do something for my child without saying 'we'll see,' I don't want that. I want to be able to afford corn flakes when he wants them, not waiting for the grant. So for me, success is still rare. I think most of the things I need, they need me to work. (Khanya)

Family challenges, and especially relationship dynamics, were frequently mentioned in relation to self-awareness, along with an awareness of how they have been shaped (and often strengthened) by their experiences. In terms of coping with these challenges and experiences, many mentioned not caring or ignoring the negative things that people say in order to protect themselves, and other coping strategies included learning to manage their emotions and being able to speak to others about their challenges. Emotional awareness was one of the topics covered in the *Bukhali* intervention sessions.

There is a task in the emotions chapter where there is a question that is asking you how you are feeling today. So, I usually would do that task to help adjust myself so that I can understand what type of person I am. I used to be short tempered and would snap very quickly. As I attended the sessions, I gained more confidence and learn to let go of my anger. I need understand my mood first before going out to socialize with others. (Lindiwe)

3.2.2. Self-assertion

For all participants, their self-awareness, self-confidence and self-acceptance contributed to their ability to stand up for themselves and express their needs in a mature way.

Self-confidence is trusting yourself and knowing how far you can go. How do you see yourself? Do you need to be praised by the next person, or do you see yourself as being beautiful on your own without being told? Do you feel like you need a second opinion to validate yourself? Confidence is being confident on your own and loving yourself the way you are … Take care of yourself and love yourself because no one will love you if you do not love yourself. (Thato)

This expression took different forms: self-reliance, prioritizing themselves, perseverance, and self-protection. Self-reliance was the most prominent and involved participants needing to take care of themselves and others. Prioritizing themselves was related to this and it was about knowing and getting what you want. Perseverance included "managing to overcome everything", finding help and pushing yourself.

There are things that I was supposed to know about, there is no one that is going to do them accept for me, so that is where I saw that I am going to have to stand for myself and help myself … [What is your understanding of succeeding?] For me, when I have finished studying and being able to do things that I want in my way. (Neo)

I have to stand up for myself because my younger siblings are looking up to me. One day my mother said to my siblings that, 'one day I am going to leave you guys.' My younger sister responded saying, 'you can go, our sister is now doing grade twelve and will finish school and take care of us.' This is one of the things that pushes me to do something better. (Ayanda)

I have confidence … one thing that helped me to be confident is being positive about it and knowing what I want. (Lebo)

I could say I am a go getter person, so when I tell you that I want to focus on my health and education, so my problem was financially, no one was going to sponsor me, but I am glad that I got my learnership, so it is going to help me. [And what is your understanding of self-confidence in general?] It is to believe in yourself. (Anele)

Self-protection involved speaking up for themselves about how not to be treated or when something is bothering them in a relationship or needing to "fight back". Two participants spoke about balancing putting themselves first as a form of self-protection, with being strong and caring for others as a form of altruism (discussed in more detail below).

The study has helped me a lot and made me realize or see the woman that I am supposed to be, not an object that men will use … I do not allow my situation to define me, I always fight back and that is what makes me different … Take care of yourself and love other people. Do not be selfish, judgmental … Create a comforting sport within yourself for another person. The most important thing is to take care of yourself. (Lindiwe)

Yes, self-acceptance … I accept myself that okay fine, each and everything is on my shoulders, and I must not put myself under stress about who is going to think about what. And I always say to my mom that you better throw everything to me, rather than trusting on other family members. So I always told myself that because I am the one that helps mom, I have to be strong so that she can also be strong, so the fact that she can see that I am strong, will give her strength to also be strong. (Thato)

3.2.3. Altruism

Many of the participants spoke in positive terms about helping others, although few of them specifically articulated this as a way of coping with their distress. This included caring for and loving family members (often despite challenges), helping others in need in their community, and generally showing sympathy, comfort and love to others. As much as participants described their willingness to help others, they did not seem to be in relationships where they are helped or where they experience reciprocal giving and receiving of help.

Here when you get here, there are strangers and we do not know each other but you can come to me and I will support you. If we are from the same community and you come and tell me that you do not have money to

go to school, if I have money, I will just give you so that you can go to school. (Ayanda)

I should love my siblings even though we have challenges and things that are created by our parents, that I should not blame them for the things that our parents do because they didn't do anything, they don't know anything, that I must support them if they need my support and I must always be there for them as their older sister, when they need me. (Busi)

For those who had a child or children, they spoke about teaching their child to share and doing things for their child. One participant even mentioned not committing suicide for her child's sake – an extreme act of altruism in the face of overwhelming mental health difficulty.

When I am able to help other kids and do things for my child, I will see that I have succeeded. (Neo)

I feel it wouldn't be fair to my child if I kill myself, because the pain I felt when I lost my mom, he'd also feel it and I don't know how they'll treat him. So it's better to be here … I won't deprive him an opportunity to have a mom … I had to be resilient. Sometimes you have a reason, sometimes you don't. My reason was my child. That's the only reason. If I did not have a child … I would have hanged myself or use mixture. [What mixture?] Aspirin … take eye drop, Rattex, mix them together and drink. [For suicide?] Yes. (Khanya)

3.2.4. Sublimation

Most participants mentioned positive activities that helped them to channel difficult emotions or thoughts, with the most common activity being some form of exercise, e.g. jogging, dancing, lifting weights. Some made the connection between physical and mental health in their explanation of why exercise helped them. Other positive activities mentioned were reading, listening to music, and practicing "self-hygiene", with possibly less positive but still socially acceptable activities such as and doing chores or cleaning, and screen time.

I listen to music and maybe dance or go for an exercise or something, just that my mind doesn't remain glued to that thing. [What exercise do you do?] I run. (Busi)

Physical and mental combine for me, because normally when you jog, your mind focuses on the running, it doesn't focus on other things. And it drops your anger like boxing. The more you punch that bag, you release mental tension. So it's exercising the body and mind at the same time … You're always training your mind, you destress somewhere somehow. Even weights, when you are angry, you push weight with that anger, releasing that tension. (Khanya)

I like to read, so I read novels … I keep myself busy, even around the house, and if there is nothing to do, I keep myself busy around the house, I clean. (Anele)

3.2.5. Anticipation

Many participants showed the ability to anticipate potentially difficult situations, and plan in advance for how they would deal with them. This anticipation most frequently related to situations that they felt would cause them stress, often in relation to communicating with others. They also repeatedly mentioned anticipating health problems. Managing of expectations was a common anticipation strategy, along with being aware of and avoiding 'red flags' and triggers as a means of self-care. In some cases, this involved isolating themselves and introspecting when they were triggered.

The trial study on its own has also opened my eyes as a woman. It has taught me that as a woman you need to take care of yourself and take note of red flags. I should be able to see things which are wrong and as a woman I should not go through them. Some of the things that I went through I was not supposed to have going through them, I was supposed to have been protected. (Busi)

Like I have mentioned that I do snap sometimes out of the blue. If there is something irritating that is going to happen, I can feel it before it does. In order to avoid getting irritated or angered I isolate myself. While in isolation I will do a self-introspection asking myself what exactly is happening why this thing bothers me so much. I will then try to find a solution on how I should react or behave. (Lindiwe)

3.2.6. Suppression

Similarly, many participants seemed able to consciously push unpleasant emotions or thoughts out of their awareness temporarily to avoid distress. For some, this was more generally about not focusing on negative things ("push aside those negative words") or changing their mindset ("focus on what I want", "teach myself how to grow up"). Whereas for others, this was about specifically managing a situation ("try calm myself down", not responding in anger), focusing on something important to them ("shift my focus and focus on my studies"), or choosing to let go of something (forgiving, forgetting).

The things that makes me cope is that I don't focus on all the negative things, I say, yes, my mom did this negative thing, but there is also a good thing that she did, you know, so that is what makes me cope … It is because I don't focus on negative things like before, so now I focus on the good things, even when you do something bad to me, I don't live for revenge, you know, if you do bad things to me, I will wake up and make coffee for you, and if you ask me if I was not angry, I will tell you that I am not angry, I am over what happened yesterday and today is today. (Anele)

Like I categorize everything, I take stress and put it in its box and focus on what I want. (Thato)

I decided to let go of everything he has ever said to me and forgive him … [How is the relationship now?] It is good because I decided not to hold any grudges and forgave him. (Ayanda)

3.3. Less common defence mechanisms

Relatively fewer participants exhibited immature defence mechanisms within the levels of disavowal, major image distorting, and action. At the disavowal level, denial was mentioned in relation to potential health issues and not seeing dysfunctional behaviour of a partner. Projection involved taking out pain on the wrong person, and rationalization related to avoiding counselling and speaking about problems.

I end up saying wrong things. I take out my pain to the wrong person. I am supposed to take it out in other places like the gym, but I take it out on wrong places. (Khanya)

With regards to major image distorting, although participants spoke about a "bad crowd", "bad side", "talking bad", and "good people", they generally seemed to be referring more to behaviours and choices, rather than viewing others as inherently bad (splitting). While a few participants expressed aspirations about a "lavish life" were about having everything you want (usually material possessions, e.g. cars, house, clothes), without being able to verify the extent to which these aspirations are realistic, we would be cautious to label these as autistic fantasies.

The only mechanism at the action level that was mentioned by a few participants was acting out, and this included substance use (some past, some current), suicidal ideation, having a short temper, at physically punishing their child.

It [relationship with child] is okay, but sometimes he makes me mad and I hit him. [Why do you think you react like that?] I don't know … I was playing with the child, but not like how I am right now, before I would get irritated, but now I am better. (Neo)

Defence mechanisms within the level of mental inhibition were also

displayed by fewer participants (and less often). These included repression, isolation of affect (not wanting to talk about instability, feelings or challenges), intellectualization ("made peace", seeing employment as the solution to all their problems), dissociation (distance from family members), and displacement (dependency on a partner because of relationship with father).

> *We are people that don't like to talk about our feelings, we would rather talk about things that happen outside, but when her have to be serious, we are not … we rather avoid things like that, we don't talk about that, the challenges. (Anele)*

3.4. How they make sense of themselves

3.4.1. Minor image distorting: "I'm one of a kind"

3.4.1.1. Devaluation of others versus idealization. In spite of the more mature defence mechanisms exhibited, all participants showed the mechanism of devaluation of others, particularly other young women in their community. Although participants were not overtly judging these young women, they frequently described them as succumbing to peer pressure, "hustling", engaging in transactional sex (some refer to it as prostitution), partying, drinking, and taking drugs. Participants perceived these women as having lost hope, with "no goals or dreams", and "living life as it is."

> *You can see how they become. They become wild, they'd do anything to get what they want. They are struggling, and they have to hustle for something to smoke. (Lebo)*

> *Others are influenced by peer pressure because most of them have children, like I think only five of us in my area don't have children, the rest have children, like they make it like it's competition, others smoke crystal … Like this thing of having different partners for money, I feel like they are prostituting but in a smart way, like they are selling their bodies for money, that's what I think, but they think that is their way of getting money … they give me money so that is quick money that I didn't have to work for, yet at the end of the day they are the ones that are getting damaged, boys don't get damaged maybe, I don't know. (Busi)*

> *There are people who are willing to change but we also have others who are dwelling in the past and want to make their problems their destination. There are others I tried recruiting to join the study, but they refuse yet they did not have anything to do. (Lindiwe)*

Similar to how they viewed their own resilience as being related to having patience, they saw these women as lacking in patience and resilience, and one participant described them as "unable to be resilient" or "non-resilient", which contrasts with how they described themselves as resilient. Participants also felt that these women were not willing to change, and not trying to better their lives, especially through employment.

> *It's easy to spot a resilient and non-resilient person … There is a difference between the two of us … A resilient person is similar to the working person, they can stand whatever. A non-resilient person has no boundaries … I'm on the resilient side because, for my side, if my child is hungry, I have to make a plan … A non-resilient person is easily spotted. When the baby cries, she'd get angry and leave the baby behind and expect the baby to be silent when she comes back. (Khanya)*

> *I would say we do have more resilient people who do not want to be defeated by their circumstances. There are others who are not, and they end up feeling suicidal. You know if you can allow drugs to control you, you are defeated. I would say differs from one person to another. There are those who can handle the pressure and be resilient but there are those who cannot, and they end up taking drugs and others killing themselves. (Lindiwe)*

Only one participant highlighted that the lack of employment of these women would make them more susceptible to abuse, and some acknowledged that these young women did not have role models in the community. This is arguably a form of displacement (mental inhibition level) as most of them do not explicitly blame men within the community for the behaviour of these young women. Nor do they fully acknowledge young women's financial stressors, lack of support and poverty that contribute to transactional sex or using substances as a coping mechanism.

> *Most young women are becoming victims of abuse because they want money. They go for older men and become abused. They are dating because they need money, which is connected to unemployment. (Ayanda)*

> *My area [name] doesn't have success … I will not see any motivation, like even one person that I can say is my role model … The* norm *with the township is that once you become successful, you leave the township. So I will not say that I can pinpoint that this person has been successful or not, so it's not easy to even identify a role model … And when you leave you don't even come back. (Thato)*

To a lesser extent, devaluation of others was directed at other family members, especially fathers, and men in general. This was mostly to do with the lack of support they provided them, some in extreme circumstances when a participant was raped.

> *I have developed so much hatred towards men and if I were to be a serial killer, I would only kill men because the pain that have gone through was caused by men … When I told her [aunt] that my uncle had raped me, instead of her sympathizing and defending me she just said it served me right, I asked for it. Those are not words that should be uttered by someone who is also a mother. (Lindiwe)*

The mechanism of idealization was not evident, since while participants spoke highly of some individuals in their lives, either past or present, these were deemed to be realistic appraisals about these individuals in terms of the key support role they were described to have played for participants.

3.4.1.2. Omnipotence versus devaluation of self. In contrast to how participants saw other young women in their community, almost all participants displayed the defence mechanism of omnipotence, as a way of setting themselves apart from these other women. They saw themselves as "one of a kind" – different and special, as role models, and as individuals who are making it on their own, working for themselves, and not defined by their situation.

> *[Would you say you are different?] Yes, I am … Because of my peers, like they want boyfriends who have money, others don't have dreams, others like friends and friends come with a lot of influence, I am don't that. So those are the things that make me feel like I am different because I am able to stay at home alone and I don't stress about that, I accept everything that I have and it's fine if I don't have other things because I know that I will have some other time in the future. (Busi)*

> *I would say I am a resilient woman because I refuse to accept defeat. I refuse to allow my difficulties to define me as a person. I know that I have been through a lot, but I know I can do better for myself rather than expecting handouts from people. I do need help from people, but I do not need to be spoon fed for everything. I do feel like I am a resilient woman because I fight back, I refuse defeat. (Lindiwe)*

These same participants who contrasted themselves with other young women in their community and saw themselves as different and special, also exhibited the defence mechanism of devaluation of self, and admitted to having low self-confidence. This lack of confidence may be due to what others have said to them which impacted their self-esteem, and the lack of social support many of them experience, including the

lack of healthy relationships where they experience reciprocal giving and receiving of help mentioned earlier.

> *I do not have confidence because I have lived with people who have made me to have low self-esteem and be less confident … You know when you are living in a community and going to a certain school, there will always be those who will make you feel less of yourself. (Ayanda)*

> *Everything that my father said to me, I believed it. He would insult me and all that, and I'd take it. When someone compliments me, I would think they are fooling me. But when someone told me I am ugly, I would believe it, because I would believe I deserve nothing nice. What my father and other people spoke, that's what matter, that's the truth. (Khanya)*

How these minor image distorting mechanisms operate within these participants is highly nuanced, and it is evident that these participants hold these complexities and tend not to reduce these dynamics into all good or all bad. Specifically, while participants' set themselves apart from other women in their community, they do not overtly judge them. Furthermore, the young women that participants spoke about are their sisters, peers, and relatives. It is possible that the social proximity of these young women may temper participants' perceptions of them, but nonetheless, participants still see themselves as different. And while they see themselves as "one of a kind", they lack confidence.

3.4.2. Self-talk and agency

Self-talk came up often in the interviews, suggesting that this is a common adaptive strategy (at the high adaptive level) used by participants. It is possible that they develop this ability to talk to themselves because they do not have others to talk to, or that no one is talking to them. There were examples of self-talk as a form of anticipation when participants were preparing themselves for a stressful or fearful situation, or as a form of suppression. Self-talk was also evident in how participants used the mechanisms of self-observation and self-assertion, and related to their self-confidence and self-care.

> *I am someone who has fear, but before I leave, I tell myself that I am going to school, and those people are not going to do anything to me, and there is nothing they are going to tell me, and then I go out. (Neo)*

> *… that's how I take care of myself, that even though you can see that these people are talking about you, you must just ignore them and focus on yourself, you must just tell yourself that you are all right as you are and don't allow easy things to drag you down. (Thato)*

> *I just told myself that I was not going to give up no matter what, I was going to continue and see what this thing was taking me … I just told myself that I should not give up even though it was difficult I should just continue and see where it would lead to. Sometimes I would just tell myself that, 'no.' Sometimes you just need to forget about everything. (Ayanda)*

Participants' comments about their self-observation, particularly about their awareness of their role in situations, suggests a sense of agency. This is supported by their self-talk, as well as what they spoke about in terms of making positive choices and decisions, taking responsibility, and setting goals. However, it seems that this sense of agency is something that they have cultivated for themselves, rather than them being given agency over their life situations, or their health. It is evident that there is a need for them to negotiate agency as they navigate interpersonal relationships, cultural and social constraints, and the health care system. The maturity of their defences supports this ongoing negotiation.

3.4.3. Self-isolation versus affiliation

All participants spoke in some way about isolating themselves, and not needing help from others, or not wanting to depend on others. Many participants expressed the preference for spending time (or working) alone, having no or few friends, and/or not spending time or communicating with their friends. Some were focused on their child.

> *I don't like friends, I don't have friends … I used to like being around friends, a lot, I would wake up and do what I had to do and then go out and come back late. [What changed then?] I think growing up changed me, because I think the more I grow up, is the more I see that friends are not important in my life. (Busi)*

> *Compared to others as I say that I don't like going out and I don't even have friends, like right now I will meet people and greet them and then I will just go inside and stay in the house. I can say that I have decided to leave their struggle … I saw that the only way to survive the situation was to stay at home, buy data and look for work, like that was the only thing that saw as something that would remove me from that environment. (Thato)*

Linked to this, as well as to the implied value judgements of other young women's behaviour, most participants exhibited a strategy of what could be characterized as mature avoidance – of alcohol, smoking, drugs, "going out", walking at night, dating, multiple partners, pregnancy, and gossiping. Some participants spoke about staying at home as part of this avoidance, which involved extended periods of sleeping for a few of them; this could be a form of dissociation as a way of disconnecting from their situation.

> *I think the majority smokes, drink and go out a lot. I don't do all those things … They go out to drink, come back injured, others come back dead, kidnapped and lost. [So you see yourself different because you do none of those things?] Yes. (Lebo)*

> *I am always indoors, you will never find me in a drama, that so and so was gossiping about so and so, I just like to be alone. (Busi)*

> *Besides waking up at six to go for jogging, that's the only thing I do. Then I come back and stay inside. I don't go out anymore expect when needed. I sleep the whole day, use TikTok of which is not really life. (Khanya)*

This self-isolation and mature avoidance link to how they see themselves as different and special. However, it is possible that others in their family and community see them as loners, rather than how they see themselves – as "one of a kind", resilient, independent women. Furthermore, this self-isolation could relate to the point made earlier about participants engaging in self-talk due to a lack of others to talk to.

Despite the frequency of defence mechanisms at the high adaptive level, the mechanism of affiliation was not mentioned often by participants, with some participants not mentioning it at all. Along with the talk about self-isolation and avoidance, these participants appear to have low affiliation. A few mentioned receiving social support from their family or boyfriend. Those who did speak about their affiliation with others most frequently mentioned their connection with their Health Helpers and other *Bukhali* trial participants. This suggests that the trial is a place where they are able to move away from isolating themselves, and move towards affiliation with others. The way in which all participants spoke about their healthy relationships with Health Helpers further supports this affiliation, with a number of them saying their Health Helper was "like a sister". Health Helpers were described as individuals who are good, trustworthy, resilient, understanding, and non-judgmental – "someone you can open up to". They were said to communicate well and "care and shows you the way"; they motivate, encourage, support and help. Some participants specifically mentioned the impact of this relationship and the trial on reducing their self-isolation.

> *I found love here. When I spoke to [Health Helper name], she was a very understanding person … I am not ready for the study to end but now even the last point does not want to come I was hoping that I was going to continue this study through being pregnant … I enjoyed and loved being part of the study. This study is very beneficial, even though I was not talking to [Health Helper name] every day, those times when we got to talk, I got the comfort of feeling like I am at home. (Lindiwe)*

What [Health Helper name] helped me with is, she likes to laugh, she likes to talk, so the thing she encourage me with is to not be alone and to talk to people, communicate with people, just be you, enjoy life, you know. (Anele)

All participants agreed that the trial aligned with their interest in health, and had been helpful for learning about their health (physical and mental), managing their emotions, and changing their health behaviours. They all mentioned at least one behaviour change: screen time, sleep, physical activity, diet, or sexual activity.

Before joining this study, I used to eat whatever I wanted to eat and sleeping a lot. I would just exercise without checking what I needed to eat as well. Exercising and junk food does not go to together. After coming here I realized that I should not sleep a lot and if I exercised, I needed to eat healthy. (Ayanda)

I learnt to eat healthy, which is something you don't really listen to when you live in the township, so Bukhali has helped me with that … Now I watch the food that I eat, and sleeping, I used to be on the phone most of the time. I would eat, sleep, phone. But now I am active, yes, I eat well and I exercise. (Anele)

Apart from the health benefits of the trial, participants also felt it had a positive impact on their mental health, interactions with family, and building their self-confidence and self-acceptance. Participants' exposure to the trial environment, Health Helpers and other participants, and the validation they receive through this exposure could affirm their self-confidence and self-acceptance.

It has improved a lot because I didn't have time to sit down and listen, and I would get angry when he calls me. But now I listen accordingly, I respond like a mom, not someone from the street. So it has helped. For me when I

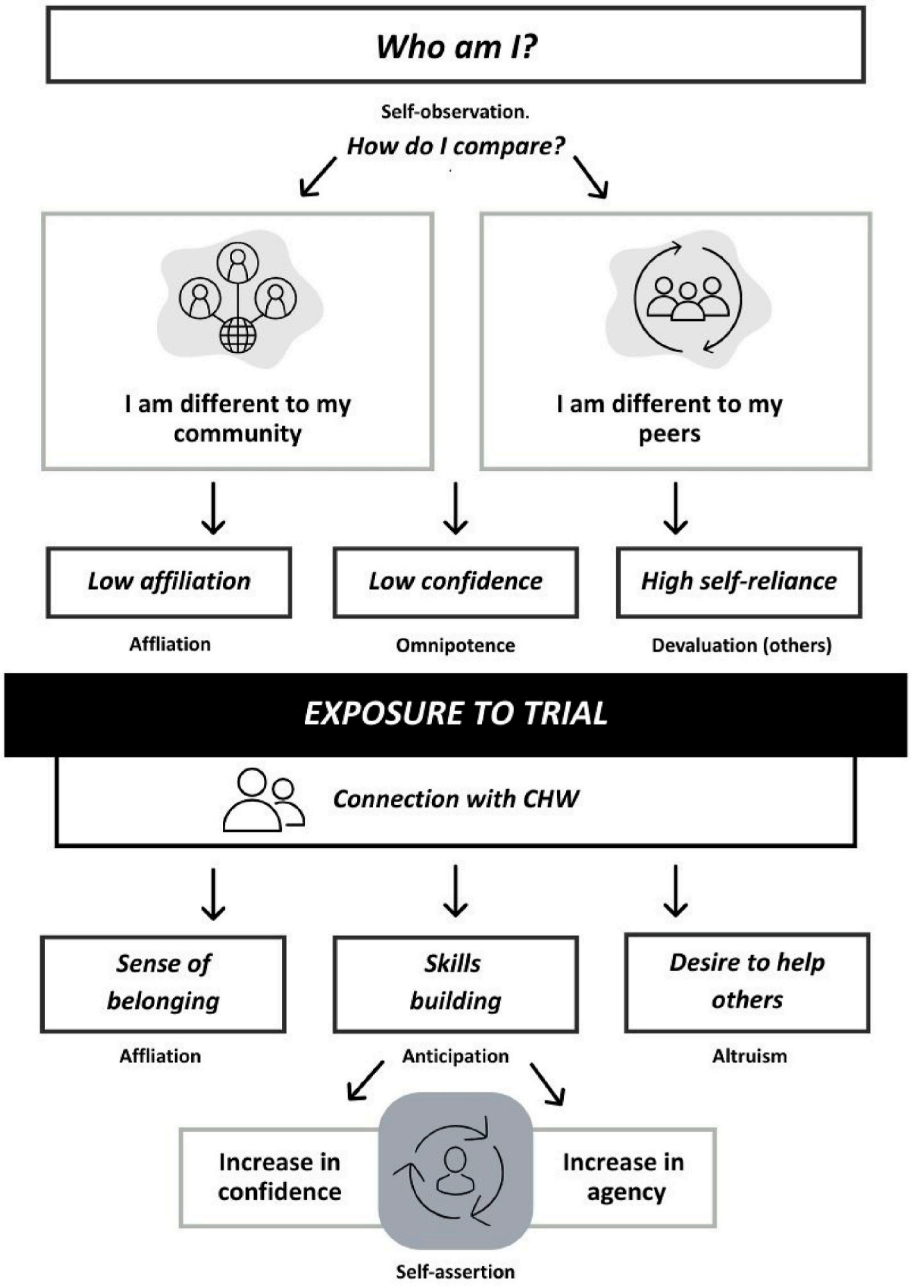


Fig. 1. Defensive functioning in positive deviants.

say Bukhali has helped, it's not only with books, but also helped me mentally. (Khanya)

For me, the study helped me because it boosted my self-confidence, something that I didn't have … It has helped me, because it has taught me to know more about my health, and it helped me be aware of things that I didn't know, and I can say that my mental health is better than before. (Anele)

The study taught me that how to take care of myself, how do I eat, how do feel about myself, how to love myself, and also be able to eat well and include both my child and my mom on my diet … I don't have a person that I can talk to most of the time … so the study has taught that when I read and sometimes when I speak to [Health Helper name], and then I could see that okay fine at least now I found someone that I could speak to, and the study has helped me to read more and know more … meeting different people helps you to be able to open up, and also we are not being judged and you take interest in everything that we say, and you also allow us to express our feelings and be free. (Thato)

4. Discussion

Within the challenging socio-economic landscape of Soweto, characterized by persistent poverty, health risks, and complex family dynamics, a group of young women in the *Bukhali* trial appear to thrive despite significant adversity. Their thriving points to the operation of internal psychological processes that support resilience and adaptation. The lens of defensive functioning reveals, first, that these young women are primarily operating at more mature levels of defensive functioning, which enables them to manage emotional and relational challenges more adaptively. Second, it provides a framework to interpret the nuanced ways in which they make sense of their lives and negotiate personal change, particularly through their engagement with the *Bukhali* trial and the support of Health Helpers. Fig. 1 illustrates this process of change.

Interestingly, self-isolation, typically associated with low affiliation, emerged as a nuanced strategy. Rather than signalling social withdrawal, it functioned as a deliberate means of avoiding negative influences and preserving space for personal growth. Despite this distancing tendency, participants also formed meaningful connections with people (e.g. Health Helpers, peers in the trial). These relationships provided emotional support and guidance, illustrating a dynamic interplay between emotional self-protection and selective social engagement in their defensive functioning. These findings indicate that these young women are actively constructing their social identities in relation to their broader social context. Many participants expressed a tendency to distance themselves from the perceived group identity of other young women in their community, often described in devaluing or critical terms, while aligning themselves with a more positively valued collective identity as participants in the *Bukhali* trial. This differentiation can be understood both as a defensive process, supporting self-esteem and coherence in the face of social adversity, and as an expression of emerging social identity work. Participants' references to altruism and helping roles further suggest that their sense of self is partly shaped through caring for others within their households and communities, positioning 'being a helper' as an important dimension of their social identity.

a conceptual model from the *Bukhali* trial.

These findings suggest that mature and contextually adaptive defence mechanisms contribute not only to psychological protection but also to an active, agentic form of resilience. This aligns with broader psychoanalytic literature emphasizing the critical role of mature defence mechanisms in promoting psychological well-being and personality integration, particularly in the face of adversity (Cramer, 1987, 2015; Hoffman, 2016; Kernberg, 1988; Perry, 2014). While international research supports these links, literature focusing on defensive functioning in South Africa remains limited, with some research focused on defensive functioning in formal organizational settings. For example, one study explored humour as a defence against workplace anxiety (Coetzee and Cilliers, 2012); others have investigated collective defences in academia (Cilliers and May 2010) and institutional responses to anxiety in post-apartheid environments (Auld and Cartwright, 2018; Mnguni, 2012).

Our study findings suggest that nurturing thriving within adversity could be achieved in some part by cultivating mature defence mechanisms, particularly self-observation and self-assertion. These insights also signal potential leverage points for psychosocial intervention, shifting the narrative from one of survival to one of agency. The sense of agency identified from participants' comments aligns with other research on women's agency, particularly regarding their health, that has also linked agency to goal setting, choices and decisions, and the need to negotiate and navigate agency over time (Raj, 2020; Roest et al., 2023; Vizheh et al., 2023). However, the complexity of this agency for women in vulnerable settings, such to Soweto, is important to note (Campbell and Mannell, 2016; Roest et al., 2023). Acknowledging this complexity, psychological interventions could encompass support that enables women (and men) recognize their uniqueness within their community but also guide them towards seeking affiliation with other like-minded individuals within or outside their community. Furthermore, these interventions could include practical skills building around mature defence mechanisms and help women to see how they may already use some of these mechanisms as part of healthy coping strategies (e.g. exercising as sublimation, helping others as altruism), but could help to amplify these skills and expand their skill set for greater impact.

The strength of this study is that it provides an in-depth exploration of the concept of positive deviance and applies the psychoanalytic lens of defensive functioning. This dual framework is novel for the *Bukhali* trial and in South Africa, and for the field of psychology. The psychological focus of this study may be perceived as narrow, and hence a limitation of this study. However, this study forms part of a greater body of qualitative work within the *Bukhali* trial process evaluation that has explored contextual realities and structural barriers to health and wellbeing of young women in the Soweto context (Draper et al., 2025; Draper et al., 2020, 2022, Draper et al., 2023, 2024, 2025, Mabetha et al., 2024a, 2024b, 2024c; Soepnel et al., 2024a, 2024b). The study's retrospective application of the lens of defensive functioning, as well as the focus on a specific population within a localized setting may also be considered limitations of this study. However, this psychologically rich and nuanced analysis generates insights that can inform research and interventions in similarly disadvantaged environments. Moreover, the conceptual frameworks of positive deviance and defensive functioning are adaptable and could be applied in diverse settings to explore resilience in other marginalized groups. As such, the study has both immediate relevance for the *Bukhali* trial and broader applicability to interventions in global contexts marked by adversity.

In conclusion, this study showed an important connection between positive deviance and the role of mature defence mechanisms in supporting resilience among young women facing adversity. By integrating positive deviance with the theory of defensive functioning, this study provides a deeper understanding of both the internal psychological processes and observable adaptive behaviours that underpin resilience. This novel dual framework offers a powerful lens for designing strength-based, contextually sensitive interventions that align with the lived realities of marginalized groups like these young women, offering pathways for continued growth and success in the face of adversity.

CRediT authorship contribution statement

Catherine E. Draper: Conceptualization, Data curation, Formal analysis, Methodology, Project administration, Writing – original draft. **Claire Hart:** Formal analysis, Writing – original draft. **Nosibusiso**

Tshetu: Investigation, Methodology, Writing – review & editing. **Nokuthula Nkosi:** Investigation, Methodology, Writing – review & editing. **Stephen J. Lye:** Funding acquisition, Writing – review & editing. **Shane A. Norris:** Funding acquisition, Methodology, Writing – review & editing.

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Appendix A. Supplementary data

Supplementary data to this article can be found online at https://doi.org/10.1016/j.ssmmh.2025.100557.

Data availability

The authors do not have permission to share the qualitative data for this study, due to ethical concerns from the relevant Human Resource Ethics Committee about sharing qualitative interview data outside of the research team due to the risk of potentially identifying participants.

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