# A Systemic Approach to Comorbid Substance Use, Anxiety, and Depression: Applying the 5 Ps Model

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## ABSTRACT

Substance use disorders (SUD) rarely occur in isolation; they exist in a persistent, mutually reinforcing relationship with anxiety and depressive symptomatology, forming a triad that severely compromises individual and relational functioning. The urgency of integrated approaches is particularly evident in Kenya, where recent national evidence demonstrates substantial levels of alcohol, cannabis, tobacco, and other psychoactive substance use among both the general population and university students, with increasing recognition of co-occurring depressive disorders as a major public health concern (NACADA, 2022, 2024).Traditional treatment models frequently address these conditions sequentially, stabilizing substance use before treating co-occurring mood disorders, an approach that fails to account for the interlocking biological, psychological, and systemic mechanisms sustaining the triad and that frequently drives high rates of relapse. This paper proposes that the 5 Ps model (Presenting, Predisposing, Precipitating, Perpetuating, and Protective factors), long used in individualized clinical formulation, offers a superior, systemically oriented framework for conceptualizing and treating comorbid SUD, anxiety, and depression. Drawing on contemporary neurobiological, psychological, and epidemiological literature, this paper maps each of the 5 Ps onto the clinical presentation of the triad, illustrating how historical vulnerabilities, acute stressors, and self-reinforcing feedback loops interact within the family system to maintain distress. Attention is given to protective factors within the Kenyan context, where community cohesion, layperson-delivered interventions, and culturally embedded resilience offer promising, underutilized buffers against relapse. The paper concludes that integrated, concurrent treatment that engages the family system alongside the individual, and that addresses shared neurobiological substrates, is clinically necessary for sustainable recovery. Implications for private-practice clinicians managing complex; dual-diagnosis presentations are discussed, along with a call for expanded research into systemic and community-based interventions for this population.

**Keywords:** comorbidity, substance use disorder, anxiety, depression, 5 Ps model, systemic therapy

## INTRODUCTION

The intersection of substance use disorders (SUD), anxiety, and depression constitutes one of the most prevalent and clinically demanding presentations encountered in contemporary psychiatric and psychological practice. Within Kenya, substance use has become an increasingly significant mental health challenge. The 2022 National Survey on the Status of Drugs and Substance Use in Kenya reported that approximately 18% of Kenyans had used at least one psychoactive substance in the previous month, while alcohol and tobacco remained the most used substances. Importantly, the survey further established that recent substance use was associated with depressive disorders, reinforcing evidence that substance use and common mental disorders frequently coexist rather than occur independently (36). More recently, the national survey among university students revealed even higher levels of lifetime exposure to alcohol (40.5%), cannabis (18.0%), tobacco products (20.4%), and other psychoactive substances, highlighting the growing vulnerability of young adults to dual diagnosis presentations requiring integrated intervention (37). Far from being three discrete conditions that happen to co-occur, extensive epidemiological research establishes that mood, anxiety, and substance-related disorders form a tightly interwoven triad that compounds individual suffering and destabilizes the family systems surrounding the affected client. Saha and colleagues (2), in a systematic review and meta-analysis of comorbidity between

mood and anxiety disorders, demonstrated that the presence of one disorder substantially elevates the lifetime probability of the other, establishing a foundational vulnerability upon which further psychopathology, including substance use, is frequently layered. When substance use is introduced into this matrix, the clinical picture becomes markedly more complex. A case-control study by Mohamed and colleagues (1) assessing anxiety and depression among patients with SUD found significantly elevated rates of both conditions relative to healthy controls, reinforcing the view that these three presentations are not independent but reciprocally entangled.

The demographic reach of this triad is broad, cutting across age, gender, and socioeconomic status. Richert and colleagues (4) documented the profound mental health burden carried by young people entering substance abuse treatment in Sweden, noting that early-onset comorbidity tends to predict a more chronic and treatment-resistant trajectory across the lifespan. This pattern extends into specific vulnerable populations as well; Zhou and colleagues (3) found that women of reproductive age experiencing depression and anxiety disorders encounter distinct systemic and structural barriers, and correspondingly worse treatment outcomes, when they present with concurrent substance use. Taken together, this literature makes clear that the triad is not confined to a narrow demographic band but instead threads through adolescence, adulthood, and the vulnerabilities associated with reproductive-age womanhood, family caregiving roles, and early treatment-seeking populations.

Despite this weight of epidemiological evidence, clinical practice has been slow to catch up conceptually. Mental health and addiction services are, in many settings, still organized around the assumption that a client's substance use must be stabilized before their anxiety or depression can be meaningfully addressed, or vice versa. This sequential logic, while administratively convenient, does not reflect the way these conditions actually behave in the therapy room: symptoms of anxiety intensify cravings, depressive withdrawal deepens isolation from family supports, and substance use in turn worsens both mood states, producing a self-sustaining cycle that resists interventions aimed at only one node of the system. The result, all too often, is a revolving door of partial treatment, relapse, and renewed crisis, with the relational and family dimensions of the presentation left largely unaddressed.

This paper argues that conceptualizing the triad of SUD, anxiety, and depression through a systemic, relational lens, using the 5 Ps model of clinical formulation, offers a more holistic and ultimately more effective pathway for both understanding and treating these complex, co-occurring presentations. Rather than isolating the individual's neurobiology from the family system that surrounds them, the 5 Ps model insists on an integrated formulation that accounts for presenting symptoms, historical predisposition, acute precipitants, perpetuating feedback loops, and, critically, the protective resources, cultural and relational, that can be mobilized in service of recovery. The remainder of this paper synthesizes the relevant literature on the triad, introduces the 5 Ps framework in greater depth, applies each of its five components to the clinical presentation of comorbid SUD, anxiety, and depression, and closes with implications for clinicians working in private practice and community-based settings, with particular attention to the protective resources available within the Kenyan context. Such an approach aligns with Kenya's growing policy emphasis on integrated management of co-occurring substance use and mental disorders, community-based treatment, and family-cetered prevention strategies (36).

## LITERATURE REVIEW

### The Triad: Self-Medication and Shared Mechanisms

To treat this triad effectively, clinicians must first understand the mechanisms that drive its persistence. The self-medication hypothesis remains the dominant explanatory paradigm, proposing that individuals turn to psychoactive substances as a maladaptive coping strategy to manage the distress of untreated or undiagnosed anxiety and depression. Anker (5) bridged psychiatric, psychological, and neurobiological perspectives to explain how co-occurring alcohol use disorder and anxiety develop through a reciprocal, mutually reinforcing process rather than a simple cause-and-effect chain. This bidirectional relationship was thrown into sharp relief during recent global stressors; McPhee and colleagues (9) observed that during the COVID-19 pandemic, a marked decrease in environmental reward combined with rising depressive symptoms to drive coping-motivated drinking, illustrating how situational adversity can rapidly accelerate the self-medication cycle across an entire population. Similar trends are increasingly evident in Kenya, where national evidence has identified substance

use as a significant correlate of depressive symptoms, suggesting that maladaptive coping strategies may similarly underpin co-occurring mental health and substance use disorders within the Kenyan population (36).

Beyond behavioral coping, a growing body of neurobiological research indicates that mood disorders and addiction share common neural substrates rather than merely co-occurring by chance. Xu and colleagues (7) identified the nucleus accumbens, a central hub of the brain's reward circuitry, as a shared neurobiological target implicated in both depression and addiction, suggesting that the reward system is altered in overlapping ways by each condition. This shared neurobiology often manifests clinically as pronounced anhedonia, the diminished capacity to experience pleasure, which in turn complicates the recovery process. Destoop and colleagues (8), in a narrative review, detailed how addiction-induced anhedonia mimics and intensifies the anhedonia already present in comorbid mood disorders, creating a physiological barrier that keeps clients locked out of naturally rewarding experiences and increasingly reliant on substances to feel anything at all.

Relational and developmental paradigms add a further layer to this picture. Attachment theory offers a lens through which the psychological roots of the triad can be understood. Schindler (6) mapped the theoretical models and empirical evidence linking insecure attachment styles to the development of substance use disorders, arguing that early relational deficits, disruptions in the caregiving bond, inconsistent attunement, or outright neglect, predispose individuals not only to mood dysregulation but to subsequent chemical dependency as a substitute source of soothing. This attachment-informed perspective is especially relevant for systemic and family therapists, since it locates the origin of the triad not solely within the individual's neurochemistry but within the relational context in which that neurochemistry developed.

**The Gap: A Need for Systemic and Relational Literature**

Notably, most of the literature reviewed above, though rich in neurobiological and individual-psychological detail, remains centered on the individual as the unit of analysis. Studies of nucleus accumbens function, anhedonia, and self-medication motives illuminate what is happening inside a single client's brain and behavior, but they say comparatively little about what is happening around that client, within their marriage, their family of origin, or their broader community. Even attachment-informed work, while inherently relational in its theoretical roots, is frequently applied in the literature to explain individual vulnerability rather than to guide concrete, systemic intervention. This represents a meaningful gap: if the triad of SUD, anxiety, and depression is, as the evidence suggests, sustained in large part by relational and systemic feedback loops, family conflict, enabling or accommodating behaviors, intergenerational patterns of coping, then the field requires more literature, and more clinical frameworks, explicitly oriented toward the family system rather than the individual in isolation. The 5 Ps model, introduced in the following section, is offered here as one such framework, precisely because its structure compels the clinician to consider not only individual predisposition and neurobiology but also the perpetuating and protective dynamics operating at the level of the family and community.

## THEORETICAL FRAMEWORK

Given the neurobiological, behavioral, and relational complexity documented above, clinicians require an organized, evidence-based structure for case conceptualization, one capable of holding individual and systemic factors together rather than forcing a choice between them. The 5 Ps model, comprising Presenting, Predisposing, Precipitating, Perpetuating, and Protective factors, offers precisely this kind of formulation structure. Although historically applied primarily within individualized mental health treatment planning, its extension into family and systemic therapy has been validated across a range of complex clinical presentations. Baudinet and colleagues (10), for example, demonstrated the utility of structural formulation within eating disorder-focused family therapy, showing that organizing complex psychological and relational data into the 5 Ps allows clinicians to identify systemic feedback loops, patterns that repeat and sustain the disorder within the family system, and to target interventions at the specific point in the loop where change is most achievable.

Applying the 5 Ps model to the triad of SUD, anxiety, and depression helps bridge the persistent gap identified above, between individual pathophysiology and systemic, relational impact. Nemeroff (11), in a comprehensive review of the pathophysiology and optimal treatment of depression, argued that effective psychiatric care requires moving beyond simple symptom reduction toward a holistic understanding of the illness's

developmental trajectory, its origins, its maintaining conditions, and the resources available to interrupt it. The 5 Ps model operationalizes this kind of holistic thinking. It requires the clinician to ask not only what is happening in the present (Presenting), but what historical vulnerabilities set the stage for it (Predisposing), what immediate events triggered the current crisis (Precipitating), what mechanisms, biological, psychological, and relational, are keeping the client locked in the cycle (Perpetuating), and, critically, what strengths and resources, individual, familial, and cultural, already exist and can be mobilized in service of change (Protective). It is this final component, Protective factors, that most clearly distinguishes the 5 Ps model from purely pathology-focused frameworks, and that makes it especially well suited to the culturally embedded, strengths-oriented work this paper advocates for within the Kenyan clinical context. The framework is also consistent with emerging national recommendations advocating standard operating procedures for integrated management of co-occurring substance use and mental health disorders together with community-based outpatient treatment models (36).

## Core Analysis: Applying The 5 Ps Model To The Triad

### Presenting Factors

In the therapy room, the triad of substance use, anxiety, and depression rarely presents as three tidy, separable complaints. More typically, clients report a diffuse and overwhelming picture of acute emotional dysregulation, panic attacks, pervasive sadness, sleep disturbance, and anhedonia, occurring alongside active substance use or intense, intrusive cravings. Kenyan epidemiological data indicate that alcohol remains the most commonly used psychoactive substance, followed by tobacco and cannabis, while university students report substantial exposure to multiple psychoactive substances, suggesting that clinicians are increasingly likely to encounter clients presenting with complex comorbid symptom profiles rather than isolated disorders (NACADA, 2022, 2024). Consistent with the epidemiological findings discussed above (1, 2), this presentation is rarely confined to the individual client's internal experience alone; it spills outward into the relational system. Systemically, the presenting problem most often manifests as relational rupture: escalating marital conflict, breakdowns in parent-child communication, or outright familial alienation resulting from the unpredictability, secrecy, and erratic behaviour that accompany intoxication and mood instability. A spouse may present describing exhaustion and hypervigilance around a partner's unpredictable moods; a parent may present in crisis after discovering a young adult child's substance use has escalated alongside worsening depressive withdrawal. In each case, what brings the family into the therapy room is not simply the individual symptom picture, but the relational damage it has caused, which is precisely why a systemic, rather than purely individual, formulation is required from the outset.

This relational framing of presenting factors has direct implications for intake and assessment. A clinician who assesses only the identified client's substance use history and mood symptoms risks missing the full clinical picture, the ways in which family members have organized their own coping, roles, and communication patterns around the client's distress. Effective formulation under the 5 Ps model therefore begins with a presenting-problem assessment that explicitly maps both the individual symptom cluster and the relational sequence that accompanies it: who becomes anxious when whom, who withdraws, who confronts, and how these patterns have shifted as the substance use and mood symptoms have intensified over time.

### Predisposing Factors

Predisposing factors encompass the historical, genetic, and developmental vulnerabilities that lay the groundwork for the eventual emergence of the triad. A substantial body of literature identifies Adverse Childhood Experiences (ACEs) as a primary driver of this vulnerability. Leza and colleagues (12), in a scoping review, demonstrated a strong, dose-dependent relationship between the accumulation of ACEs and the later development of substance use disorder, such that each additional adverse experience in childhood corresponds to a measurable increase in adult SUD risk. In parallel, Tsehay and colleagues (14) found that ACEs significantly increased both the prevalence and severity of depressive symptoms among adolescents, underscoring the long reach of early trauma into later mood functioning.

The developmental timing of these adverse experiences appears to matter as much as their accumulation. Osofsky and colleagues (13) emphasized the particularly profound impact of adversity occurring during the perinatal period, a window in which foundational neurodevelopmental processes are especially sensitive to

disruption, with consequences that can echo across the individual's lifespan. Dagnino and colleagues (15) extended this line of inquiry by exploring how ACEs disrupt broader personality functioning, leaving individuals with fragile, under-resourced coping mechanisms that render them susceptible to both adult depression and later chemical dependency. These early relational and environmental disruptions do not remain purely psychological; they appear to leave a measurable imprint on brain structure and function. Stoychev (16) summarized neuroimaging findings among patients with dual diagnoses, revealing structural and functional abnormalities that often predate the onset of substance use itself, suggesting that in many cases the neurobiological vulnerability to addiction is already in place before the first substance is ever used, laid down instead by earlier mood dysregulation and adverse developmental experience.

From a systemic standpoint, these predisposing factors rarely originate solely within the individual; family-of-origin dynamics, patterns of emotional expression, intergenerational coping styles, and, in some cases, intergenerational trauma transmitted across generations, all contribute to the predisposing landscape. A thorough 5 Ps formulation therefore requires the clinician to trace not only the individual client's developmental history but the broader family narrative: how earlier generations managed distress, whether substance use or emotional avoidance were modeled as coping strategies, and how these inherited patterns have been passed, consciously or unconsciously, into the presenting generation. In Kenya, early exposure to drugs, peer influence, and widespread availability of alcohol and cannabis among young people further interact with developmental vulnerabilities to increase later risks of substance use disorders and associated psychological distress (37).

**Precipitating Factors**

Precipitating factors are the acute stressors or discrete events that trigger the onset of a current episode of distress, or a relapse into substance use following a period of stability. For individuals already predisposed toward mood disorders and addiction, environmental instability functions as a powerful catalyst. Dawson-Rose and colleagues (18) documented how the intersection of trauma history, mental health symptoms, and substance use is acutely precipitated among transitional-age youth by the sudden loss of housing stability, illustrating how the abrupt removal of safety and structure can trigger immediate, maladaptive self-medication in an already vulnerable population. Among Kenyan university students, academic pressure, peer influence, financial constraints, easy availability of psychoactive substances, and online access have emerged as important contextual stressors that may precipitate substance use among psychologically vulnerable young adults (37).

Within clinical populations more broadly, precipitating stressors can carry life-threatening consequences. Keen and colleagues (19) found that co-occurring mental illness and substance use disorder is strongly associated with elevated overdose risk, frequently triggered by sudden shifts in tolerance following a period of abstinence, or by acute psychiatric crises that overwhelm a client's existing coping resources. Fridell and colleagues (17) similarly demonstrated that psychiatric comorbidity is among the strongest predictors of premature death within cohorts of patients with substance use disorder, indicating that acute spikes in anxiety or depressive symptomatology frequently precede, and precipitate, the most dangerous substance use behaviors. Job loss, grief, divorce or relational rupture, and sudden shifts in family structure, such as the birth of a child, a partner's illness, or an adult child leaving home, all function similarly within a systemic formulation: they destabilize the existing equilibrium of the family system, and in doing so, reactivate both the predisposing vulnerabilities described above and the substance use that has historically served to manage them.

**Perpetuating Factors**

Perpetuating factors are the mechanisms, biological, psychological, and systemic, that keep the client locked within the ongoing cycle of the triad once it has been triggered. One major perpetuating factor at the behavioral level is polysubstance use. Crummy and colleagues (20) modeled the dynamics of polysubstance use, explaining how alternating between different substances, for instance, using alcohol to manage anxiety and stimulants to counteract depressive fatigue, produces complex, overlapping withdrawal syndromes that make stabilization exceedingly difficult without coordinated clinical intervention.

At the cognitive and physiological level, Smith and colleagues (22) used Bayesian computational modeling to reveal that individuals with depression, anxiety, and substance use disorder share a common failure to accurately

update interoceptive precision estimates, meaning they consistently misread their own internal bodily signals, interpreting ordinary physiological arousal as catastrophic panic, or ordinary fatigue as a slide into deep depression. This miscalibration perpetuates the urge to self-medicate, since the substance offers a rapid, if temporary, correction to an internal state the client cannot otherwise interpret or regulate. This cycle is reinforced further by neuroimmune mechanisms; Namba and colleagues (23) detailed how substance use triggers neuroinflammatory processes that biochemically perpetuate mood disorder symptoms, producing a vicious biological feedback loop in which substance use worsens the very depression and anxiety it was initially used to relieve. Psychologically, Cayoun and Shires (21) explained this same dynamic through the lens of co-emergence reinforcement, describing how the temporary relief a substance provides is instantly and powerfully reinforcing, which in turn makes the slower, more effortful process of interoceptive desensitization, learning to tolerate emotional discomfort without immediate escape, exceedingly difficult to sustain.

Systemically, family dynamics can perpetuate the cycle just as powerfully as these biological mechanisms, often without any member of the family intending to do so. Well-meaning accommodating behaviors, a spouse covering for missed work obligations, a parent providing financial support that indirectly funds continued substance use, or family members avoiding direct conversation about the substance use altogether to preserve a fragile peace, can each inadvertently remove the natural consequences that might otherwise interrupt the cycle. Similarly, chronic, unresolved marital or family conflict generates the very anxiety and depressive affect the substance use is being used to manage, creating a closed loop in which the relational system and the individual's symptomatology sustain one another. A 5 Ps formulation that fails to map these systemic perpetuating patterns, focusing only on neurobiology and individual cognition, will consistently underestimate what is keeping the client stuck.

**Protective Factors: The Kenyan Context**

Protective factors, the final and most strengths-oriented component of the 5 Ps model, encompass the resources that mitigate risk and actively promote resilience. Examining these factors within the Kenyan context offers particularly rich insight into how localized, culturally embedded systemic supports can buffer against the triad, even amid considerable structural adversity. Despite substantial systemic challenges, Kenyan communities have repeatedly demonstrated profound resilience in the empirical literature. Nyongesa and colleagues (27), in a study of young people living with HIV on the Kenyan coast, identified strong family cohesion, community acceptance, and targeted psychosocial support as powerful protective indicators against common mental disorders, findings that translate directly to the population under discussion in this paper, given the substantial overlap between chronic illness, stigma, and mood vulnerability.

Innovations in community-based care further illustrate the systemic protective factors available within this context. Osborn and colleagues (26) demonstrated the efficacy of the Shamiri intervention, a layperson-delivered program, in meaningfully reducing anxiety and depressive symptoms among Kenyan adolescents, offering strong evidence that community-based, non-specialist care can interrupt the progression of mood disorders before they escalate to the point of requiring self-medication through substances. This finding carries significant implications for a resource-constrained mental health system: protective factors need not always originate from formal clinical services but can be cultivated through trained community members embedded within existing social networks.

Protective factors must nonetheless be understood contextually rather than assumed to operate uniformly across all populations. Jorns-Presentati and colleagues (29), in a systematic review of mental health among sub-Saharan adolescents, cautioned that cultural stigma can actively erode otherwise available community support, undermining its protective potential. This caution is especially salient for marginalized groups; Harper and colleagues (25) documented severe mental health challenges among sexual and gender minority individuals in Western Kenya, where a comparative lack of systemic protection and social acceptance substantially exacerbates the risk for both substance use and depression. Conversely, when systemic and cultural support is genuinely present, even profoundly traumatized populations demonstrate meaningful resilience; Im and colleagues (24) found that strong social support networks and culturally relevant coping strategies significantly mitigated the co-occurrence of PTSD, depression, and anxiety among Somali refugees resettled in Kenya. Ssewanyana and colleagues (28) further established that adolescents in rural sub-Saharan settings frequently engage in multiple

overlapping health risk behaviors simultaneously, underscoring the need for multi-layered, culturally attuned protective interventions rather than single-issue programming. Taken together, this literature suggests that protective factors within the Kenyan context, extended family networks, community and church-based support, and spiritual or religious meaning-making, represent an underutilized clinical resource that, when deliberately incorporated into treatment planning, can substantially strengthen a client's capacity to interrupt the cycle of comorbid substance use, anxiety, and depression. National recommendations increasingly emphasize positive parenting programmes, strengthening family interventions, school-based prevention, faith-based collaborations, community outpatient treatment, and integrated mental health services as protective mechanisms capable of reducing both substance use and mental health burden (36).

**Clinical Implications**

The synthesis offered by the 5 Ps model points clearly toward one central clinical conclusion: sequential treatment, addressing substance use first and the mood disorder later, or vice versa, is fundamentally mismatched to the actual mechanics of this triad. Yule (30) argued forcefully for the integration of treatment for co-occurring mental health conditions and substance use disorder, noting that addressing the shared neurobiological and systemic factors simultaneously produces significantly lower relapse rates than approaches that treat each condition in isolation. For the private-practice clinician managing these complex, dual-diagnosis presentations, this means resisting the administrative pull toward referring out the substance use component while retaining only the anxiety or depression treatment and instead building or coordinating a genuinely concurrent treatment plan from the outset.

Guidelines for this integrated approach continue to evolve, but existing evidence already offers meaningful direction. Torrens and colleagues (33) provided clinical practice guidelines emphasizing the necessity of combining pharmacological management, addressing the shared neurobiological substrate discussed earlier in this paper, with concurrent psychological intervention for adult patients presenting with depression and comorbid substance use disorder. Hides and colleagues (31), in a review of psychological interventions, similarly supported therapeutic approaches that target mood regulation and substance refusal skills at the same time, rather than in sequence, reinforcing the practical viability of concurrent treatment even outside of highly specialized dual-diagnosis units.

Systemically, mental health services, and individual clinicians working within private practice, must adapt their models to treat the family unit alongside the individual client, not the individual in isolation. Fantuzzi and Mezzina (32) reviewed the organization of community health services for dual diagnosis, advocating for integrated care teams that include family therapists working alongside psychiatrists and community support workers, precisely the kind of team-based, systemically minded model this paper advocates for. In a private-practice setting such as a Nairobi-based systemic therapy practice, this translates into concrete practice adjustments: routinely inviting spouses, parents, or other key family members into at least a portion of the treatment process, even when the identified client is presenting individually for anxiety or depression; screening explicitly for substance use during intake rather than waiting for it to surface later; and building relationships with psychiatric and medical providers so that pharmacological and psychotherapeutic care can proceed genuinely in parallel rather than in sequence.

Unfortunately, a meaningful gap remains at the level of global standardization. Alsuhaibani and colleagues (34) found that international clinical guidelines addressing mental health and substance use frequently lack inclusivity and fail to provide specific, actionable protocols for dual-diagnosis presentations, leaving individual clinicians to rely on flexible, adaptable frameworks such as the 5 Ps model to guide day-to-day practice in the absence of more prescriptive guidance. This gap is particularly consequential in contexts such as Kenya, where formal dual-diagnosis protocols and specialized treatment infrastructure remain limited relative to the scale of need. In this environment, the 5 Ps model offers a distinct practical advantage: it does not require specialized dual-diagnosis infrastructure to implement, only a clinician willing to systematically assess presenting, predisposing, precipitating, perpetuating, and protective factors, and to build treatment planning that engages the family system and available cultural and community resources rather than relying solely on individual, symptom-focused intervention. For clinicians managing these cases in private practice, this also means actively identifying and mobilizing the protective factors, extended family involvement, community and faith-based support, culturally

resonant coping strategies, that the literature reviewed above identifies as particularly potent within the Kenyan context, treating these not as peripheral supports but as core, clinically actionable components of the treatment plan itself.

## CONCLUSION

The comorbidity of substance use, anxiety, and depression constitutes a pervasive, biologically and relationally entrenched triad that demands a sophisticated, integrated clinical response rather than the fragmented, sequential care it too often receives. By applying the 5 Ps model, clinicians are equipped to conceptualize these complex presentations through a genuinely systemic lens, mapping the historical, predisposing traumas that establish vulnerability, the acute, precipitating triggers that ignite crisis, and the interlocking biological and relational feedback loops that perpetuate the cycle once it has begun. Crucially, the model also elevates the importance of protective factors, resisting the pull toward a purely pathology-focused formulation and instead demonstrating how community-level and culturally embedded resources, such as those documented within the Kenyan context throughout this paper, can foster profound and durable resilience.

As Masten and colleagues (35) argued in their multisystem review of resilience in development and psychopathology, resilience is not best understood as a fixed individual trait but as a dynamic, systemic process, one that emerges through the ongoing interaction between an individual and the relational and community systems that surround them. This reframing carries direct clinical weight for the triad discussed in this paper: recovery from comorbid substance use, anxiety, and depression is unlikely to be sustained through individual symptom management alone but is far more achievable when clinicians actively engage the family system, mobilize available cultural and community resources, and pursue genuinely concurrent, rather than sequential, treatment of the mood and substance use components of the presentation.

Future research should continue to build on this systemic foundation, with particular attention to controlled outcome studies evaluating family-inclusive and community-integrated interventions for dual-diagnosis populations within sub-Saharan African contexts, where the existing evidence base, while promising, remains comparatively limited relative to the scale of clinical need. Clinicians, researchers, and policymakers alike must continue to champion integrated, concurrent treatment models that honor the full complexity of the human system in which this triad is embedded, moving the field beyond narrow symptom management and toward a more holistic, relational, and ultimately more sustainable model of healing.

Within Kenya and many low- and middle-income countries, increasing rates of substance use alongside growing mental health burden underscore the need for integrated, systemic approaches to assessment and treatment. Embedding the 5 Ps framework within family therapy, community mental health, addiction services, and primary healthcare may improve formulation, strengthen relapse prevention, and promote sustainable recovery through simultaneous attention to biological, psychological, relational, and socio-cultural determinants of health (36,37).

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