Low-Dose Buprenorphine for Interpersonal & Affective Dysregulation in BPD

Quick Reference for Primary Care | Off-Label | Emerging Evidence | v0.2

RATIONALE

The endogenous opioid system regulates attachment, social bonding, and separation distress. BPD is associated with **reduced baseline opioid tone** (Stanley, Bandelow). Buprenorphine's unique profile—partial μ-agonism + κ-antagonism—may stabilize this system: raising baseline tone, attenuating reinforcing surges from crisis/self-injury, and reducing stress-induced dysphoria.

KEY EVIDENCE

- **Yovell et al. (2015) RCT:** Ultra-low-dose buprenorphine (0.1–0.2 mg SL) significantly reduced suicidal ideation vs placebo. Post-hoc BPD subgroup showed particularly robust response.
- **Kaschor case report:** Opioid-naive BPD patient; 2 mg → 4 mg → 6 mg titration guided by crisis contact frequency. Crisis events fell from 41 to 12 (15-mo comparison), then to zero after dose optimization.
- **Stanley & Bandelow:** Neuropeptide model implicating opioid dysregulation in BPD; CSF studies showing reduced β-endorphin/met-enkephalin in NSSI.

WHEN TO CONSIDER

- **Comorbid OUD:** Standard of care; monitor affective outcomes alongside OUD metrics
- **Comorbid chronic pain + dysregulation:** Dual analgesic/affective benefit
- **Prominent interpersonal dysregulation:** May not require prior SSRI/stabilizer failure if opioid mechanism is the target
- **Treatment-resistant:** After ≥2 medication trials + psychotherapy without adequate response

REGULATORY

Schedule III. X-waiver eliminated (2023). Any DEA-registered practitioner with Sched. III authority may prescribe. Off-label use is legally permissible with documented rationale.

DOSING FRAMEWORK

Phase Guidance

Start 0.1–0.2 mg SL once–twice daily (Yovell protocol). Requires compounding or patient-prepared dilution below 2 mg.

Titrate 0.1–0.2 mg increments. Guide by functional endpoints (crisis contacts, therapy attendance, self-injury freq).

Expected Yovell trial: started 0.1–0.2 mg SL 1-2x/day, titrated in 0.1 mg steps; mean dose 0.44 mg/day. Refractory cases: stepwise to higher doses guided by functional outcomes.

Goal Minimum effective dose. Not PRN—scheduled baseline modulation.

BASELINE CHECKLIST

- PDMP review (screen for naltrexone/LDN)
- Urine drug screen
- LFTs if hepatic risk factors
- Suicide risk assessment (C-SSRS)
- Benzo/CNS depressant review
- Dissociative screening (DES-II)
- Measurable treatment goals (ZAN-BPD or MSI-BPD)
- Informed consent (off-label, evidence limitations, dependence risk, opioid analgesic interference)

KEY CONTRAINDICATIONS & CAUTIONS

- **Absolute:** Concurrent naltrexone (any form)—precipitates withdrawal
- **Caution:** Concurrent benzos/CNS depressants, active uncontrolled SUD, pregnancy (obstetric collab required)
- **Monitor:** Reduced opioid analgesic efficacy—patient should carry documentation for emergency providers

MONITORING

Titration (months 1–3): Monthly minimum. Assess sedation, mood, SI, dissociation, substance use. PDMP + UDS per risk.
Stable: Q3 months max. Reassess functional goals each visit.
Discontinue if: No benefit after 8–12 wks at therapeutic dose, misuse/diversion, or patient request. Gradual taper—physical dependence occurs even at low doses.

Full guide: bpd.fyi/resources | contact@bpd.fyi | *v0.2 Draft – March 2026*