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ICD-11-6A20 Schizophrenia

Component 1: Written Report

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1.Introduction

ICD-11 classifies schizophrenia as a disorder within schizophrenia or other primary psychotic disorders. It is characterised by marked disturbances in thinking, perception, self-experience, cognition, affect, volition, and behaviour. Clinically, schizophrenia is associated with symptoms such as delusions, hallucinations, disorganised thinking, experiences of passivity or control, negative symptoms, severely disorganised behaviour, and, in some cases, psychomotor disturbances including catatonia. ICD-11 states that at least two characteristic symptoms must be present for most of the time over a minimum period of one month, and at least one of these must be a core symptom such as delusions, hallucinations, disorganised thinking, or experiences of influence, passivity, or control. The symptoms must not be better explained by another medical condition, substance use, medication effects, or withdrawal. Schizophrenia may present as a first episode, a recurrent disorder, or a persistent condition, reflecting its variable and often long-term course. This diagnosis remains highly relevant in health and social care because it can significantly impair social functioning, independent living, employment, and overall quality of life. This report critically examines the ICD-11 classification of schizophrenia, its diagnostic criteria, treatment and rehabilitation approaches, current controversies, and recommendations for improving practice and policy (Uwtsd.ac.uk, 2026).

2. Classification of Schizophrenia in ICD-11

In ICD-11, schizophrenia is classified within Chapter 6, *Mental, Behavioural or Neurodevelopmental Disorders*, under the grouping *Schizophrenia or other primary psychotic disorders*. The use of the term disorder reflects its status as a formally recognised psychiatric diagnosis within an international clinical classification system, rather than a general description of illness. ICD-11 describes schizophrenia as involving disturbances across multiple mental domains, including thought, perception, self-experience, cognition, volition, affect, and behaviour. In addition to defining the disorder through its symptom profile, ICD-11 also codes its course longitudinally, including first episode, multiple episodes, and continuous illness, alongside specifiers such as currently symptomatic, partial remission, and full remission. A major change from older systems is the abandonment of traditional subtype labels such as paranoid, catatonic, residual, and undifferentiated schizophrenia. This reflects a more

contemporary approach to classification, recognising that schizophrenia is better understood as a heterogeneous disorder with varied symptom presentations and illness trajectories, rather than as a small number of fixed subtypes (Uwtsd.ac.uk, 2026).

2.1 Diagnostic Criteria

For a diagnosis of schizophrenia, ICD-11 requires that at least two characteristic symptoms are present for most of the time over a period of one month or more. At least one of these must be a core psychotic symptom, namely persistent delusions, persistent hallucinations, disorganised thinking, or experiences of influence, passivity, or control. Other recognised features include negative symptoms such as blunted affect, avolition, alogia, asociality, and anhedonia, as well as severely disorganised behaviour and psychomotor disturbances including catatonia. This reflects ICD-11's recognition of schizophrenia as a multidimensional disorder that extends beyond the narrow association with hallucinations and delusions alone. Diagnosis also requires that the presentation is not better explained by another medical condition, substance use, medication effects, or withdrawal. This exclusion is clinically important because psychotic symptoms may also occur in other disorders, including mood disorders with psychotic features, trauma-related conditions, delusional disorder, and acute and transient psychotic disorder (NHS, 2021).

2.2 Diagnostic Process and Clinical Considerations

The diagnosis of schizophrenia involves both structured clinical assessment and professional judgement, requiring evaluation over time rather than dependence on a single symptom. In practice, clinicians gather information from the individual, direct observation, family members, and other relevant informants in order to assess symptom persistence, severity, and functional impact. ICD-11 also requires attention to developmental, cultural, and gender-related factors during assessment. For example, schizophrenia in childhood is rare and may be confused with neurodevelopmental conditions such as autism spectrum disorder or attention deficit hyperactivity disorder. Similarly, culturally normative spiritual beliefs, migration-related distress, or unfamiliar forms of expression may be misinterpreted as psychosis when practitioners lack cultural competence. Gender-related differences in age of onset, presentation, and social response may also influence diagnostic decisions. Therefore,

although ICD-11 provides a structured diagnostic framework, accurate diagnosis depends substantially on clinical judgement, careful differential diagnosis, and awareness of the wider social and cultural context (Mayo Clinic, 2024).

3. Treatment Approaches

The treatment of schizophrenia typically involves a combination of antipsychotic medication, psychological therapy, and multidisciplinary community support. Antipsychotic medication remains the main clinical intervention, particularly for reducing positive symptoms such as hallucinations, delusions, and severe thought disorder, and continued use may help to reduce the risk of relapse. However, its effectiveness is often limited by adverse effects, including sedation, weight gain, metabolic complications, and extrapyramidal symptoms, which may reduce adherence and negatively affect quality of life. Medication alone is also often insufficient in addressing negative symptoms, cognitive impairment, and the wider social consequences of schizophrenia. For this reason, psychological and psychosocial interventions such as cognitive behavioural therapy for psychosis, family intervention, psychoeducation, and relapse prevention are important components of care, as they can support insight, coping, emotional regulation, and recovery. Nevertheless, these approaches are not equally accessible, and their effectiveness may depend on service quality, continuity of care, and the person's level of engagement. Therefore, effective treatment for schizophrenia is usually not purely medical, but holistic, person-centred, and recovery-oriented (NHS, 2023).

3.1 Rehabilitation Measures in ICD-11 and Practice

According to Gaebel, Kerst and Stricker (2020), ICD-11 classifies schizophrenia using course specifiers such as first episode, multiple episodes, and continuous course, together with clinical status qualifiers including currently symptomatic, partial remission, and full remission. This is important for rehabilitation because it recognises that schizophrenia may follow an episodic, recurrent, or persistent trajectory, each of which may require different levels of intensity, duration, and continuity of support.

Rehabilitation therefore extends beyond symptom control and focuses on improving social, educational, occupational, and personal functioning. In practice, it may involve supported accommodation, vocational rehabilitation, community mental health follow-up, and recovery-oriented care planning, particularly for people with complex psychosis and long-term functional impairment. These approaches can help promote autonomy, community living, and social inclusion, but their effectiveness often depends on the availability of coordinated and sustained services. In many settings, rehabilitation is limited by underfunding, fragmented systems of care, and inadequate attention to wider social determinants such as housing, employment, and stigma. Therefore, although ICD-11 provides a useful framework for understanding the course of schizophrenia, effective rehabilitation depends less on classification alone than on the availability of continuous, integrated, and person-centred support (Gaebel, Kerst and Stricker, 2020).

4. Current Debates and Emerging Issues

A major ongoing debate surrounding schizophrenia concerns the way it is classified and treated within contemporary psychiatry. Although schizophrenia is commonly understood through a biomedical framework, critics argue that this approach can place excessive emphasis on biological explanation while giving insufficient attention to trauma, poverty, social exclusion, discrimination, and cultural context. Another important area of debate concerns the continued use of the term *schizophrenia*, as some researchers and service-user groups argue that the label may reinforce stigma, fear, and misunderstanding. Debate also continues around treatment, particularly the dominant role of antipsychotic medication. While medication can be effective in reducing severe psychotic symptoms, critics argue that mental health services may remain too reliant on pharmacological treatment and hospital-based care, while psychological therapies, family intervention, and community-based recovery services are often less developed or less accessible. These debates suggest that schizophrenia remains not only a clinical diagnosis, but also a contested social and psychiatric construct (Lv and Luo, 2026).

4.1 The Role of Neurodivergence and Reclassification Issues

The relationship between neurodiversity and schizophrenia remains an emerging and contested area of debate. Neurodiversity is generally understood as a framework that

recognises natural variation in brain functioning and is most commonly associated with autism and ADHD rather than psychotic disorders. However, some contemporary perspectives argue that unusual perceptions, beliefs, and ways of experiencing reality should not always be interpreted solely through a pathological or deficit-based lens. This has encouraged greater attention to individuality, lived experience, and less stigmatising language in mental health discourse. Nevertheless, applying a neurodiversity framework to schizophrenia remains controversial, because schizophrenia is frequently associated with significant distress, functional impairment, and difficulties with reality testing, which many clinicians regard as distinguishing it from conditions more commonly included within neurodiversity discussions. In addition, ICD-11 has moved away from older subtype labels such as paranoid and catatonic schizophrenia, reflecting recognition that schizophrenia is highly heterogeneous and cannot be adequately understood through fixed diagnostic categories. Overall, this debate highlights the tension between more person-centred, non-deficit understandings of mental difference and the continuing clinical reality that schizophrenia often involves serious impairment and need for treatment (Nagendra et al., 2026).

4.2 Impact of These Debates on Practice and Policy

These debates shape both practice and policy. They support person-centred, trauma-informed, culturally competent care, greater service-user involvement, and a broader view of recovery including autonomy, inclusion, and quality of life. They also strengthen the case for more investment in early intervention, community services, supported housing, employment support, and psychological therapies, alongside more careful use of diagnostic labels (Parkin, 2023).

5. Recommendations

Improving schizophrenia care requires less stigmatising, more trauma-informed and culturally sensitive assessment to reduce misdiagnosis. Treatment should combine medication with psychological therapies, family support, and shared decision-making, in line with NHS guidance (NHS, 2022). Rehabilitation should also include stronger community mental health services, supported housing, and employment support. These changes reflect the Mental Health Act 1983, Mental Capacity Act 2005, Care

Act 2014, and Equality Act 2010, which promote rights, care, capacity, wellbeing, and protection from discrimination (Legislation.gov.uk, 2025).

5.1 Implications for Practice, Policy, and Further Research

These recommendations have important implications for future research, policy, and practice. In practice, professionals would require stronger training in cultural competence, trauma-informed care, and collaborative care planning. Mental health systems would also need to invest more in community-based services, early intervention, and psychosocial rehabilitation rather than relying mainly on crisis response and hospital admission. At policy level, reform should prioritise stigma reduction and greater service-user involvement. Future research should examine how trauma, social inequality, and cultural context influence diagnosis and long-term outcomes, and how effective integrated models of care are over time. Overall, these changes support a more balanced, humane, and recovery-oriented response to schizophrenia (Oup, 2024).

6. Conclusion

In conclusion, schizophrenia is a complex mental disorder that requires careful classification, accurate diagnosis, effective treatment, and ongoing rehabilitation. Although ICD-11 provides a clear framework for understanding the disorder, important debates remain around stigma, treatment approaches, and the influence of social context. A balanced approach to schizophrenia should combine clinical knowledge with person-centred, trauma-informed, and recovery-oriented practice. Improving outcomes therefore requires better services, reduced stigma, and stronger community-based support.

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