Although dementia praecox or schizophrenia has been considered a unique disease entity for the past century, its definitions and boundaries have changed considerably over this period. Despite changing definitions, the construct of schizophrenia does convey useful information: (i) patients diagnosed as having schizophrenia do have some real disease—they experience both suffering and disability; (ii) a diagnosis of schizophrenia does suggest a distinctive clinical profile—a characteristic long-term course; an admixture of positive, negative, and cognitive symptoms; likelihood of benefit from antipsychotic treatment; and (iii) schizophrenia satisfies criteria for a valid diagnostic entity better than almost any other psychiatric diagnosis. On the other hand, the concept of schizophrenia has serious shortcomings. First, it is not a single disease entity—it has multiple etiological factors and pathophysiological mechanisms. Second, its clinical manifestations are so diverse that its extreme variability has been considered by some to be a core feature. Third, its boundaries are ill-defined and not clearly demarcated from other clinical entities. Whereas the ICD-11 process has just begun, in DSM-5 several proposed revisions to address these limitations are being field-tested. For example, instead of current subtypes and course specifiers, the heterogeneity of schizophrenia might be significantly explained by the interplay between variations in: (a) illness dimensions and intermediate phenotypes; and (b) distinct stages of schizophrenic illness. Better delineation of schizoaffective disorder and clarification of the nosological status of catatonia are two additional major initiatives. The DSM-5 approach to providing a more useful description of schizophrenia will be reviewed and the ICD-11 process thus far will be summarized.