INI CET Psychiatry

Sample Paper – 3

Duration: 14 Minutes **Maximum Marks: 15**

Instructions

- This paper contains **15** Multiple Choice Questions (Single Best Response), modelled on the Psychiatry content of **INI CET** (Institutes of National Importance Combined Entrance Test) conducted by AIIMS New Delhi.
- The **15-question** length matches the number of Psychiatry items you actually meet in the real 200-question paper.
- Each correct answer carries **+1 mark**. There is **negative marking of one-third (0.33) mark** for every incorrect answer; unattempted questions carry no penalty.
- Every question has **exactly one best answer**. Choose the single most appropriate option.
- Attempt this practice paper in one timed sitting of about **14 minutes**, the pace the real computer-based test demands.

Mood and Anxiety Disorders

Q1. A patient develops marked, out-of-proportion fear whenever confronted with a particular situation such as crowded open spaces or public transport, actively avoids these situations, and fears that escape would be difficult if anxiety struck. This situational fear and avoidance is characteristic of:

(A) A phobic anxiety disorder (specific phobia and agoraphobia)

(B) Generalised anxiety disorder

(C) A manic episode

(D) Obsessive-compulsive disorder

Q2. A patient has had a chronic, low-grade depressed mood present for most of the day, more days than not, for more than two years, without ever meeting the full criteria for a major depressive episode. The most likely diagnosis is:

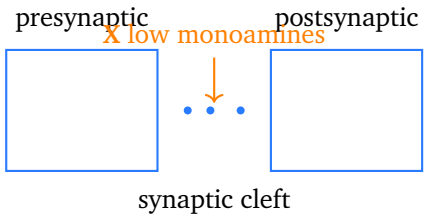
(A) Bipolar affective disorder

(B) A single major depressive episode

(C) Dysthymia (persistent depressive disorder)

(D) Cyclothymia

Q3. The synaptic schematic below marks (**X**) a reduced amount of monoamine neurotransmitter in the synaptic cleft. According to the monoamine hypothesis, depression is associated with a functional deficiency chiefly of:



(A) Dopamine and acetylcholine

(B) GABA and glutamate

(C) Histamine and glycine

(D) Serotonin and noradrenaline

Psychotic Disorders

Q4. A patient has a full depressive or manic episode occurring concurrently with schizophrenic psychotic symptoms, and also has at least two weeks of delusions or hallucinations in the absence of prominent mood symptoms. The diagnosis is:

(A) Schizophrenia

(B) Bipolar disorder with psychotic features

(C) Major depression with psychotic features

(D) Schizoaffective disorder

Q5. Which of the following is a **good** prognostic factor in schizophrenia?

(A) Insidious, gradual onset

(B) Poor premorbid social functioning

(C) Acute onset with prominent mood symptoms and good premorbid function

(D) Predominant negative symptoms

Q6. A dominant person with a delusional disorder shares an identical delusion with a close, dependent relative who lives with them; in the second person the belief resolves once the two are separated. This is:

(A) Folie a deux (shared psychotic disorder)

(B) Delusional disorder

(C) Schizophrenia

(D) Schizoaffective disorder

Substance Use and Organic Disorders

Q7. A brief four-item screening tool asks about attempts to *Cut down*, *Annoyance* at criticism of drinking, *Guilt* about drinking and a morning *Eye-opener*. This questionnaire is used to screen for:

(A) Alcohol dependence (the CAGE questionnaire)

(B) A major depressive episode

(C) Generalised anxiety disorder

(D) Opioid dependence

Q8. A chronic alcoholic develops a persistent, largely irreversible inability to lay down new memories (anterograde amnesia) together with confabulation, following untreated thiamine (vitamin B1) deficiency. This is:

(A) Delirium tremens

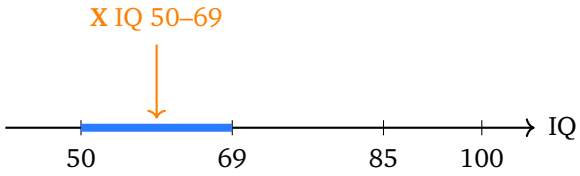
(B) Korsakoff psychosis

(C) Alcoholic hallucinosis

(D) Wernicke encephalopathy

Child, Neurodevelopmental and Personality Disorders

Q9. The IQ scale below marks (**X**) an IQ in the 50 to 69 range, accompanied by deficits in adaptive functioning. Together these findings indicate:



(A) Average intelligence

(B) Borderline intellectual functioning

(C) Profound intellectual disability

(D) Mild intellectual disability

Q10. A child of normal general intelligence has persistent difficulty with accurate and fluent word reading, poor spelling and weak decoding, well below the level expected for age despite adequate schooling. The diagnosis is:

(A) Intellectual disability

(B) Specific learning disorder (dyslexia)

(C) Attention-deficit hyperactivity disorder

(D) Autism spectrum disorder

Q11. A pattern of preoccupation with orderliness and perfectionism, rigidity and stubbornness, excessive devotion to work and inflexibility about morals, at the expense of flexibility and efficiency, indicates which personality disorder?

(A) Borderline (emotionally unstable) personality disorder

(B) Obsessive-compulsive (anankastic) personality disorder

(C) Histrionic personality disorder

(D) Schizoid personality disorder

Psychopharmacology and Therapeutics

Q12. Which is the most appropriate first-line treatment for severe depression with active suicidal intent or depressive stupor with catatonia, its main adverse effect being transient memory impairment?

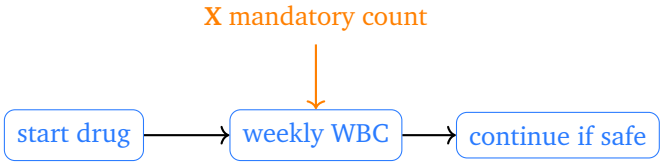
(A) Long-term psychotherapy used alone

(B) A single low-dose SSRI with no review

(C) Electroconvulsive therapy

(D) Watchful waiting without treatment

Q13. The monitoring flow below marks (**X**) a mandatory regular white-cell count. This antipsychotic, reserved for treatment-resistant schizophrenia and able to cause life-threatening agranulocytosis, is:



(A) Haloperidol

(B) Risperidone

(C) Clozapine

(D) Olanzapine

Emergency Psychiatry and Miscellaneous

Q14. A young woman develops sudden paralysis of both legs immediately after a severe emotional stressor; thorough investigation finds no neurological cause and she appears strikingly unconcerned about the disability. The most likely diagnosis is:

(A) Malingering

(B) Conversion (dissociative) disorder

(C) Somatic symptom disorder

(D) Factitious disorder

Q15. A patient is persistently preoccupied with the fear of having a serious illness, misinterprets normal bodily sensations as signs of disease, and remains anxious despite repeated normal investigations and firm medical reassurance. The diagnosis is:

(A) Somatic symptom disorder (illness anxiety / hypochondriasis)

(B) Conversion disorder

(C) Generalised anxiety disorder

(D) Delusional disorder

Detailed Solutions

Q1.

Solution

Concept – phobic anxiety disorders: Phobias are marked, situational, out-of-proportion fears leading to avoidance.

Step 1 – read the pattern: The fear is triggered by a specific situation (crowded open spaces, public transport), not by free-floating worry.

Step 2 – name the avoidance: The patient **avoids** the situation and fears that escape would be difficult if panic struck; this situational fear-and-avoidance is the hallmark of a phobic anxiety disorder, spanning specific phobia and agoraphobia.

Why the other options are wrong:

- B, generalised anxiety: is persistent, free-floating worry not tied to one situation.
- C, a manic episode: is elated, overactive mood, not fear and avoidance.
- D, obsessive-compulsive disorder: features intrusive thoughts with rituals, not situational phobic avoidance.

Final Answer: A phobic anxiety disorder (specific phobia and agoraphobia) $\Rightarrow$ $\boxed{\text{A}}$

Answer: (A) Go Back to Q1

Q2.

Solution

Concept – dysthymia (persistent depressive disorder): Dysthymia is a chronic, low-grade depression that never reaches full major-depressive severity.

Step 1 – read the duration: Depressed mood present for most of the day, more days than not, for **more than two years** is the defining timeframe.

Step 2 – match the severity: The mood never meets the full criteria for a major depressive episode, so the picture is chronic and low-grade, that is, dysthymia.

Why the other options are wrong:

- A, bipolar disorder: requires a manic or hypomanic episode, which is absent here.
- B, a single major depressive episode: would meet full criteria and need not last two years.
- D, cyclothymia: is chronic alternating hypomanic and mild depressive

swings, not sustained low mood.

Final Answer: Dysthymia (persistent depressive disorder) ⇒ C

Answer: (C) Go Back to Q2

Q3.

Solution

Concept – the monoamine hypothesis of depression: This theory links depression to a functional shortage of monoamine neurotransmitters at the synapse.

Step 1 – read the schematic: The (**X**) marker shows a reduced amount of monoamine in the synaptic cleft, that is, less transmitter reaching postsynaptic receptors.

Step 2 – name the monoamines: The core monoamines implicated in depression are **serotonin (5-HT) and noradrenaline**, with dopamine playing a lesser role; antidepressants act by raising their availability.

Why the other options are wrong:

- A, dopamine and acetylcholine: acetylcholine is not central to the monoamine theory of depression.
- B, GABA and glutamate: are the main inhibitory and excitatory amino-acid transmitters, not monoamines.
- C, histamine and glycine: are not the transmitters of the monoamine depression hypothesis.

Final Answer: Serotonin and noradrenaline ⇒ D

Answer: (D) Go Back to Q3

Q4.

Solution

Concept – schizoaffective disorder: Schizoaffective disorder mixes a full mood episode with schizophrenic psychosis.

Step 1 – read the concurrence: A full depressive or manic episode occurs **concurrently** with schizophrenic symptoms.

Step 2 – the deciding criterion: There are at least **two weeks of delusions or hallucinations in the absence of prominent mood symptoms**, which separates it from a pure mood disorder with psychosis and defines schizoaffective disorder.

Why the other options are wrong:

- A, schizophrenia: lacks a full concurrent mood episode.
- B, bipolar with psychotic features: the psychosis occurs only during mood episodes, not in their absence.
- C, major depression with psychotic features: again the psychosis is mood-congruent and confined to the depressive episode.

Final Answer: Schizoaffective disorder ⇒ D

Answer: (D) Go Back to Q4

Q5.

Solution

Concept – prognosis in schizophrenia: Certain onset and premorbid features predict a better outcome.

Step 1 – list good prognostic factors: Acute onset, the presence of **prominent mood (affective) symptoms**, **good premorbid functioning**, a clear precipitating stressor, later age of onset and predominantly positive symptoms all favour recovery.

Step 2 – select the option: Option C combines acute onset, mood symptoms and good premorbid function, so it is the good prognostic factor.

Why the other options are wrong:

- A, insidious onset: predicts a *worse* outcome.
- B, poor premorbid functioning: is a *poor* prognostic factor.
- D, predominant negative symptoms: also indicate a *poorer* prognosis.

Final Answer: Acute onset with mood symptoms and good premorbid function ⇒ C

Answer: (C) Go Back to Q5

Q6.

Solution

Concept – folie a deux (shared psychotic disorder): This is the transfer of a delusion from a dominant person to a close, dependent partner.

Step 1 – read the relationship: A **dominant** individual with a genuine delusional

disorder shares the belief with a close, dependent relative living in the same household.

Step 2 – the confirming feature: The delusion in the **secondary** (dependent) person typically **resolves once the pair are separated**, which is characteristic of folie a deux.

Why the other options are wrong:

- B, delusional disorder: describes only the primary case, not the shared, resolving belief in a second person.
- C, schizophrenia: has hallucinations and thought disorder and does not resolve on separation.
- D, schizoaffective disorder: combines a mood episode with psychosis, not a shared delusion.

Final Answer: Folie a deux (shared psychotic disorder) $\Rightarrow$ A

Answer: (A) Go Back to Q6

Q7.

Solution

Concept – the CAGE questionnaire: CAGE is a rapid four-item screen for problem drinking.

Step 1 – expand the acronym: **C**ut down, **A**nnoyed by criticism, **G**uilty about drinking, and morning **E**ye-opener form the four questions.

Step 2 – interpret: Two or more positive answers strongly suggest alcohol dependence and prompt fuller assessment.

Why the other options are wrong:

- B, depression: is screened with tools such as the PHQ-9, not CAGE.
- C, generalised anxiety: is screened with tools such as the GAD-7.
- D, opioid dependence: is not what the CAGE alcohol items assess.

Final Answer: Alcohol dependence (the CAGE questionnaire) $\Rightarrow$ A

Answer: (A) Go Back to Q7

Q8.

Solution

Concept – Korsakoff psychosis: Korsakoff psychosis is the chronic amnestic sequel of untreated thiamine deficiency.

Step 1 – read the memory picture: A persistent, largely **irreversible anterograde amnesia** (inability to form new memories) with **confabulation** in a chronic alcoholic is the classic description.

Step 2 – the mechanism: It follows untreated thiamine (vitamin B1) deficiency, often after a Wernicke episode, and damages the mammillary bodies and thalamus.

Why the other options are wrong:

- A, delirium tremens: is an acute withdrawal delirium, not a chronic memory disorder.
- C, alcoholic hallucinosis: has auditory hallucinations with clear consciousness, not amnesia.
- D, Wernicke encephalopathy: is the acute triad of confusion, ophthalmoplegia and ataxia, not the chronic amnestic state.

Final Answer: Korsakoff psychosis $\Rightarrow$ B

Answer: (B) Go Back to Q8

Q9.

Solution

Concept – intellectual disability and IQ bands: Diagnosis needs both a low IQ and deficits in adaptive functioning, with onset in the developmental period.

Step 1 – read the scale: The (**X**) marker sits in the **IQ 50 to 69** band on the schematic.

Step 2 – assign the severity: An IQ of 50 to 69 with adaptive deficits corresponds to **mild intellectual disability** (moderate is roughly 35 to 49, severe 20 to 34, profound below 20).

Why the other options are wrong:

- A, average intelligence: is around IQ 90 to 109, well above this band.
- B, borderline intellectual functioning: is roughly IQ 70 to 84, above the marked range.
- C, profound intellectual disability: is IQ below 20, far lower than 50 to 69.

Final Answer: Mild intellectual disability ⇒ D

Answer: (D) Go Back to Q9

Q10.

Solution

Concept – specific learning disorder (dyslexia): Dyslexia is a specific reading disorder in a child of otherwise normal intelligence.

Step 1 – read the profile: Normal general intelligence with persistent difficulty in accurate, fluent word reading, poor spelling and weak decoding points to a specific, not global, deficit.

Step 2 – apply the threshold: The reading skill is **well below that expected for age** despite adequate schooling, which defines specific learning disorder with impairment in reading (dyslexia).

Why the other options are wrong:

- A, intellectual disability: would show low general IQ and broad adaptive deficits, not an isolated reading problem.
- C, ADHD: is inattention and hyperactivity, not a specific reading deficit.
- D, autism spectrum disorder: is defined by social-communication deficits and repetitive behaviour.

Final Answer: Specific learning disorder (dyslexia) ⇒ B

Answer: (B) Go Back to Q10

Q11.

Solution

Concept – obsessive-compulsive (anankastic) personality disorder: This disorder centres on perfectionism, orderliness and rigidity as enduring traits.

Step 1 – match the pattern: Preoccupation with orderliness and perfectionism, rigidity and stubbornness, excessive devotion to work and inflexibility about morals are the core anankastic traits.

Step 2 – the key distinction: Unlike OCD, there are no true obsessions or compulsions; the traits are ego-syntonic and pervade the personality, so this is obsessive-compulsive personality disorder.

Why the other options are wrong:

- A, borderline: is instability of mood, relationships and self-image with impulsivity.
- C, histrionic: is excessive emotionality and attention-seeking.
- D, schizoid: is emotional detachment and a preference for solitude.

Final Answer: Obsessive-compulsive (anankastic) personality disorder $\Rightarrow$ B

Answer: (B) Go Back to Q11

Q12.

Solution

Concept – electroconvulsive therapy (ECT): ECT is the fastest-acting treatment for the most severe, life-threatening mood states.

Step 1 – read the indications: Severe depression with active suicidal intent or **depressive stupor with catatonia** are prime indications where a rapid response can be life-saving.

Step 2 – recall the main side effect: The chief adverse effect is **transient memory impairment** (mainly short-lived anterograde and retrograde amnesia), which usually recovers.

Why the other options are wrong:

- A, psychotherapy alone: is too slow when there is immediate suicide risk.
- B, a single low-dose SSRI with no review: is inadequate and slow-acting for this emergency.
- D, watchful waiting: is unsafe when the patient is acutely suicidal or in stupor.

Final Answer: Electroconvulsive therapy $\Rightarrow$ C

Answer: (C) Go Back to Q12

Q13.

Solution

Concept – clozapine: Clozapine is the antipsychotic reserved for treatment-resistant schizophrenia.

Step 1 – read the flow: The (X) marker shows a **mandatory regular white-cell count**, because the feared adverse effect is agranulocytosis.

Step 2 – name the indication and safeguard: Clozapine is used only after two

other antipsychotics have failed, and its use requires **regular full-blood-count monitoring** to detect a falling neutrophil count early.

Why the other options are wrong:

- A, haloperidol: is a typical antipsychotic that does not need mandatory white-cell monitoring.
- B, risperidone: is an atypical antipsychotic without this compulsory blood-count schedule.
- D, olanzapine: is atypical but is not the drug reserved for resistance with mandatory count monitoring.

Final Answer: Clozapine $\Rightarrow$ C

Answer: (C) Go Back to Q13

Q14.

Solution

Concept – conversion (dissociative) disorder: Conversion disorder presents with neurological symptoms that have no organic cause and follow psychological stress.

Step 1 – read the onset: Sudden paralysis of both legs appears immediately after a **severe emotional stressor**, and thorough investigation finds **no neurological cause**.

Step 2 – spot the classic sign: The patient is strikingly unconcerned about a major disability, the *la belle indifference* of conversion disorder.

Why the other options are wrong:

- A, malingering: is the *conscious* feigning of symptoms for external gain, not an unconscious process.
- C, somatic symptom disorder: features distressing physical symptoms with excessive health worry, not a pseudoneurological deficit with indifference.
- D, factitious disorder: involves deliberately produced symptoms to assume the sick role.

Final Answer: Conversion (dissociative) disorder $\Rightarrow$ B

Answer: (B) Go Back to Q14

Q15.

Solution

Concept – somatic symptom disorder (illness anxiety / hypochondriasis): Here the problem is persistent health anxiety and preoccupation with having a serious disease.

Step 1 – read the preoccupation: The patient is **persistently preoccupied with the fear of a serious illness** and **misinterprets normal bodily sensations** as evidence of disease.

Step 2 – note the reassurance failure: Anxiety persists **despite repeated normal investigations and firm reassurance**, which is characteristic of somatic symptom disorder with illness anxiety.

Why the other options are wrong:

- B, conversion disorder: presents with a pseudoneurological deficit, not health preoccupation.
- C, generalised anxiety: is broad, free-floating worry across many domains, not focused illness fear.
- D, delusional disorder: would hold a fixed, unshakeable false belief; here the fear responds partly to evidence and lacks delusional conviction.

Final Answer: Somatic symptom disorder (illness anxiety / hypochondriasis) $\Rightarrow$ A

Answer: (A) Go Back to Q15

Answer Key

Q	Ans	Q	Ans	Q	Ans	Q	Ans	Q	Ans
1	A	2	C	3	D	4	D	5	C
6	A	7	A	8	B	9	D	10	B
11	B	12	C	13	C	14	B	15	A