INI CET Psychiatry

Sample Paper – 5

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 low mood, hypersomnia, increased appetite with carbohydrate craving and weight gain every winter, with full remission each spring. The condition responds well to bright-light therapy. The most likely diagnosis is:

(A) Seasonal affective disorder (winter depression)

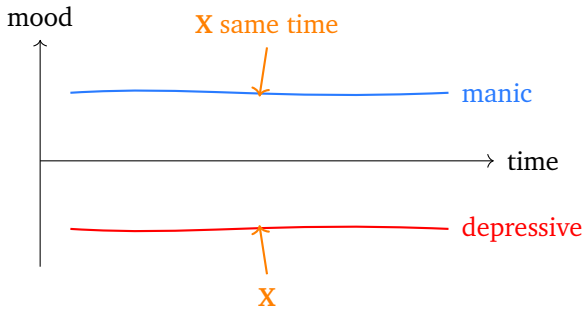
(B) Persistent depressive disorder (dysthymia)

(C) Generalised anxiety disorder

(D) Bipolar affective disorder

Q2. The schematic below plots manic features (elation, overactivity) and depressive features (tearfulness, hopelessness) occurring *together* on the

same day (marked **X**). A patient shows rapid, simultaneous manic and depressive symptoms. This state is best described as:



(A) Rapid cycling between two separate episodes

(B) A mixed affective state

(C) Schizoaffective disorder

(D) Cyclothymia

Q3. A 40-year-old woman whose husband died three weeks ago has tearfulness, poor sleep, waves of sadness triggered by reminders, and preserved self-worth, with the intensity already beginning to ease. She has no suicidal plans or psychomotor retardation. This is best regarded as:

(A) A major depressive episode requiring antidepressants

(B) Persistent complex bereavement disorder

(C) A normal grief (bereavement) reaction

(D) Adjustment disorder with psychotic features

Psychotic Disorders

Q4. A 32-year-old man holds an elaborate, systematised belief that a spy network is monitoring and plotting against him, and he hears voices commenting on his actions. His memory and orientation are intact. This clinical picture best fits:

(A) Delusional disorder

(B) Delirium

(C) Paranoid schizophrenia

(D) Obsessive-compulsive disorder

Q5. A patient with schizophrenia denies being ill, refuses treatment and insists his hallucinated voices are real people. When assessing this patient, the psychiatric term for his lack of awareness of his own illness is:

(A) Judgement

(B) Orientation

(C) Attention

(D) Insight

Q6. A young man has shown, over several years, a gradual decline into social withdrawal, blunted affect, poverty of speech, loss of drive and self-neglect, without prominent delusions or hallucinations. This presentation is best described as:

(A) Paranoid schizophrenia

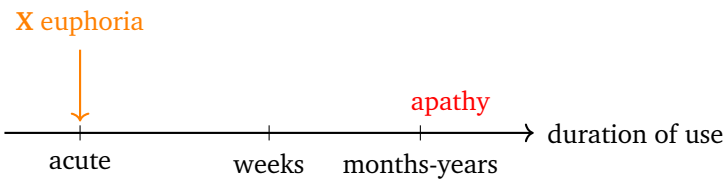
(B) Delusional disorder

(C) Simple (negative-symptom predominant) schizophrenia

(D) Catatonic schizophrenia

Substance Use and Organic Disorders

Q7. The timeline below traces a regular cannabis user: acute intoxication with euphoria and conjunctival injection (**X**), then chronic apathy, loss of drive and blunted goal-directed behaviour, with a raised risk of psychosis. The chronic apathetic picture is called:



(A) Delirium tremens

(B) Amotivational syndrome

(C) Korsakoff psychosis

(D) Wernicke encephalopathy

Q8. A 60-year-old man presents with early, marked change in personality and social conduct, disinhibition, apathy and loss of empathy, while day-to-day memory is relatively preserved early on. This pattern points to:

(A) Alzheimer disease

(B) Vascular dementia

(C) Lewy body dementia

(D) Frontotemporal dementia

Child, Neurodevelopmental and Personality Disorders

Q9. A 6-year-old boy, previously toilet-trained, repeatedly passes formed stools into his underclothes during the day, with no medical cause found. The most appropriate diagnosis is:

(A) Encopresis

(B) Enuresis

(C) Oppositional defiant disorder

(D) Conduct disorder

Q10. An 8-year-old is persistently angry and irritable, frequently loses his temper, argues with adults, actively defies rules and deliberately annoys others, but does not steal, assault or destroy property. The diagnosis is:

(A) Oppositional defiant disorder

(B) Conduct disorder

(C) Attention-deficit hyperactivity disorder

(D) Antisocial personality disorder

Q11. A man displays a pervasive sense of grandiosity, a constant need for admiration, a belief that he is special and entitled, envy of others and a striking lack of empathy. This best fits which personality disorder?

(A) Borderline personality disorder

(B) Histrionic personality disorder

(C) Antisocial personality disorder

(D) Narcissistic personality disorder

Psychopharmacology and Therapeutics

Q12. A woman of child-bearing age needs a mood stabiliser. Both sodium valproate and carbamazepine are effective, but one of them carries the highest risk of neural tube defects and should be avoided in pregnancy wherever possible. That drug is:

(A) Sodium valproate

(B) Lamotrigine

(C) Lithium

(D) Fluoxetine

Q13. A patient with major depression and coexisting chronic neuropathic pain would benefit most from an antidepressant of the serotonin-noradrenaline reuptake inhibitor (SNRI) class. Which drug belongs to this class?

(A) Fluoxetine

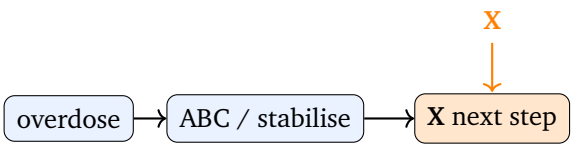
(B) Amitriptyline

(C) Duloxetine

(D) Phenelzine

Emergency Psychiatry and Miscellaneous

Q14. The flow schematic below outlines the response to a patient brought in after a deliberate overdose (**X**). After ensuring airway, breathing and circulation are stable, the single most important *immediate* step is:



(A) Discharge the patient once medically fit

(B) Medical treatment of the overdose with a risk assessment for further self-harm

(C) Start a long-term antidepressant before any assessment

(D) Arrange outpatient follow-up in six weeks only

Q15. A previously well man is found hundreds of kilometres from home, unable to recall his identity or recent past, having travelled there after a severe personal stressor, with no evidence of a head injury or organic illness. The diagnosis is:

(A) Delirium

(B) Dissociative fugue

(C) Malingering

(D) Transient global amnesia

Detailed Solutions

Q1.

Solution

Concept – seasonal affective disorder (SAD): SAD is a recurrent depression with a seasonal pattern, classically in winter.

Step 1 – read the pattern: Low mood recurring **every winter** with full remission in spring, together with **atypical** features (hypersomnia, increased appetite, carbohydrate craving and weight gain), defines the winter type of SAD.

Step 2 – the treatment clue: A good response to **bright-light therapy** is characteristic and supports the diagnosis.

Why the other options are wrong:

- B, dysthymia: is a chronic low-grade depression *without* the clear seasonal remission.
- C, generalised anxiety: is persistent worry, not seasonal low mood.
- D, bipolar disorder: requires a manic or hypomanic pole, which is absent here.

Final Answer: Seasonal affective disorder $\Rightarrow$ $\boxed{\text{A}}$

Answer: (A) Go Back to Q1

Q2.

Solution

Concept – mixed affective state: A mixed state is the simultaneous presence of manic and depressive features.

Step 1 – read the schematic: Manic and depressive symptoms plotted at the **same time** (**X**) mean the two mood poles coexist rather than alternate.

Step 2 – apply the definition: When full or prominent manic and depressive symptoms occur together in the same episode, the correct label is a **mixed affective state**.

Why the other options are wrong:

- A, rapid cycling: means several *separate* episodes within a year, not simultaneous symptoms.
- C, schizoaffective disorder: requires psychotic symptoms independent of mood.

- D, cyclothymia: is chronic, milder mood swings below episode threshold.

Final Answer: A mixed affective state $\Rightarrow$ B

Answer: (B) Go Back to Q2

Q3.

Solution

Concept – normal grief versus depression: Bereavement is a normal reaction with a self-limiting course.

Step 1 – read the course: Waves of sadness triggered by reminders, **preserved self-worth** and intensity that is *already easing* within weeks describe a **normal grief reaction**.

Step 2 – the distinction from depression: A depressive episode is suggested by pervasive worthlessness, marked psychomotor retardation, persistent suicidal ideas or symptoms that fail to ease over time; none is present here.

Why the other options are wrong:

- A, major depression: needs pervasive, non-remitting features, absent here.
- B, persistent complex bereavement: requires prolonged, disabling grief beyond the expected course.
- D, adjustment disorder with psychotic features: there are no psychotic symptoms.

Final Answer: A normal grief (bereavement) reaction $\Rightarrow$ C

Answer: (C) Go Back to Q3

Q4.

Solution

Concept – paranoid schizophrenia: The paranoid subtype is dominated by delusions and hallucinations with preserved cognition.

Step 1 – read the features: An **elaborate, systematised persecutory delusion** plus **auditory hallucinations** commenting on his actions, with intact memory and orientation, defines paranoid schizophrenia.

Step 2 – the supporting point: Cognition and orientation are preserved, which separates it from an organic delirium.

Why the other options are wrong:

- A, delusional disorder: has a single encapsulated delusion *without* prominent hallucinations.
- B, delirium: shows clouded consciousness and disorientation, absent here.
- D, OCD: involves ego-dystonic obsessions, not persecutory delusions and voices.

Final Answer: Paranoid schizophrenia ⇒ C

Answer: (C) Go Back to Q4

Q5.

Solution

Concept – insight: Insight is the patient's awareness that they are ill and that their symptoms are abnormal.

Step 1 – match the description: Denying illness, refusing treatment and insisting the hallucinated voices are real reflect **impaired insight**.

Step 2 – how it is assessed: Insight is graded from complete denial of illness through to full awareness with acceptance of the need for treatment; it is a core part of the mental state examination in psychosis.

Why the other options are wrong:

- A, judgement: is the ability to make sound decisions, a separate faculty.
- B, orientation: is awareness of time, place and person.
- C, attention: is the ability to focus, not awareness of illness.

Final Answer: Insight ⇒ D

Answer: (D) Go Back to Q5

Q6.

Solution

Concept – simple schizophrenia: Simple schizophrenia is an insidious, negative-symptom predominant form.

Step 1 – read the course: A **gradual** decline into social withdrawal, blunted affect, poverty of speech, loss of drive and self-neglect, *without* prominent delusions or hallucinations, defines simple schizophrenia.

Step 2 – the contrast: The picture is dominated by negative symptoms rather than the positive symptoms of other subtypes.

Why the other options are wrong:

- A, paranoid schizophrenia: is dominated by delusions and hallucinations.
- B, delusional disorder: centres on a fixed delusion with preserved function.
- D, catatonic schizophrenia: features marked psychomotor disturbance such as stupor or posturing.

Final Answer: Simple schizophrenia ⇒ C

Answer: (C) Go Back to Q6

Q7.

Solution

Concept – cannabis and amotivational syndrome: Chronic heavy cannabis use can produce apathy and loss of drive.

Step 1 – read the timeline: Acute intoxication gives euphoria and conjunctival injection (**X**); with chronic use, apathy, reduced drive and blunted goal-directed behaviour emerge, the **amotivational syndrome**.

Step 2 – the added risk: Regular high-potency cannabis use also raises the risk of a psychotic illness.

Why the other options are wrong:

- A, delirium tremens: is severe alcohol withdrawal, unrelated to cannabis apathy.
- C, Korsakoff psychosis: is a thiamine-deficiency amnestic state.
- D, Wernicke encephalopathy: is the acute thiamine-deficiency triad.

Final Answer: Amotivational syndrome ⇒ B

Answer: (B) Go Back to Q7

Q8.

Solution

Concept – frontotemporal dementia (FTD): FTD affects the frontal and temporal lobes, so behaviour changes first.

Step 1 – read the presentation: Early personality and conduct change, disinhibition, apathy and loss of empathy, with memory relatively spared at first, point to frontotemporal dementia.

Step 2 – the contrast with Alzheimer disease: In Alzheimer disease, *early memory loss* dominates and personality change comes later; the reverse pattern here favours FTD.

Why the other options are wrong:

- A, Alzheimer disease: begins with prominent short-term memory loss.
- B, vascular dementia: is a stepwise decline with focal neurological signs.
- C, Lewy body dementia: features fluctuating cognition, visual hallucinations and parkinsonism.

Final Answer: Frontotemporal dementia $\Rightarrow$ $\boxed{\text{D}}$

Answer: (D) Go Back to Q8

Q9.

Solution

Concept – encopresis: Encopresis is the repeated passage of stool in inappropriate places beyond the expected age.

Step 1 – apply the criteria: A child of at least **4 years** who repeatedly passes formed stools into the underclothes, with no medical cause, has encopresis.

Step 2 – supporting point: It is often associated with chronic constipation and overflow soiling, and is managed with disimpaction, a toileting routine and behavioural support.

Why the other options are wrong:

- B, enuresis: is the repeated passage of *urine*, not stool.
- C, oppositional defiant disorder: is a behavioural disorder, not faecal soiling.
- D, conduct disorder: involves serious rule violation and aggression.

Final Answer: Encopresis $\Rightarrow$ $\boxed{\text{A}}$

Answer: (A) Go Back to Q9

Q10.

Solution

Concept – oppositional defiant disorder (ODD): ODD is a pattern of angry, argumentative and defiant behaviour.

Step 1 – match the pattern: Being persistently **angry and irritable, argumentative, defiant** and deliberately annoying, *without* serious rule-breaking, defines ODD.

Step 2 – the key contrast: The absence of theft, physical aggression or destruction of property separates ODD from conduct disorder.

Why the other options are wrong:

- B, conduct disorder: involves violation of others' rights and major rules.
- C, ADHD: is core inattention and hyperactivity, not primarily defiance.
- D, antisocial personality disorder: is diagnosed in adults, not an 8-year-old.

Final Answer: Oppositional defiant disorder $\Rightarrow$ A

Answer: (A) Go Back to Q10

Q11.

Solution

Concept – narcissistic personality disorder: This disorder centres on grandiosity, need for admiration and lack of empathy.

Step 1 – match the traits: Grandiosity, a constant need for admiration, a sense of being special and entitled, envy and a striking **lack of empathy** define narcissistic personality disorder.

Step 2 – the underlying self-image: The grandiose exterior often overlies a fragile self-esteem that is easily wounded by criticism.

Why the other options are wrong:

- A, borderline: centres on instability of affect, relationships and self-image with self-harm.
- B, histrionic: is excessive emotionality and attention-seeking.
- C, antisocial: is disregard for others' rights with deceit and aggression.

Final Answer: Narcissistic personality disorder ⇒ D

Answer: (D) Go Back to Q11

Q12.

Solution

Concept – valproate teratogenicity: Mood stabilisers differ sharply in their risk during pregnancy.

Step 1 – weigh the options: Both sodium valproate and carbamazepine are effective mood stabilisers, but **sodium valproate** carries the highest risk of **neural tube defects** and of impaired neurodevelopment.

Step 2 – the practice point: Valproate should be avoided in women of childbearing potential wherever possible, using effective contraception if it must be used.

Why the other options are wrong:

- B, lamotrigine: is comparatively safer in pregnancy and is not the highest-risk agent here.
- C, lithium: carries a cardiac (Ebstein) risk but is not the neural-tube-defect answer sought.
- D, fluoxetine: is an antidepressant, not a mood stabiliser.

Final Answer: Sodium valproate ⇒ A

Answer: (A) Go Back to Q12

Q13.

Solution

Concept – serotonin-noradrenaline reuptake inhibitors (SNRIs): SNRIs block reuptake of both serotonin and noradrenaline.

Step 1 – identify the class member: Duloxetine (like venlafaxine) is an SNRI, and its dual action makes it useful in depression *with* chronic neuropathic pain.

Step 2 – the indication fit: The combination of low mood and neuropathic pain is a classic reason to choose an SNRI.

Why the other options are wrong:

- A, fluoxetine: is an SSRI, acting mainly on serotonin.

- B, amitriptyline: is a tricyclic antidepressant, not an SNRI.
- D, phenelzine: is a monoamine oxidase inhibitor.

Final Answer: Duloxetine ⇒ C

Answer: (C) Go Back to Q13

Q14.

Solution

Concept – managing deliberate self-harm: Deliberate overdose needs both medical care and a psychosocial risk assessment.

Step 1 – read the flow: Once **airway, breathing and circulation** are stabilised (**X**), the priority is **treating the overdose medically** while carrying out a risk assessment for further self-harm and suicide.

Step 2 – the safe sequence: Only after medical stabilisation and a full risk assessment can decisions about admission, safeguarding and follow-up be made.

Why the other options are wrong:

- A, immediate discharge: is unsafe before a risk assessment.
- C, starting a long-term antidepressant first: does not address the acute risk.
- D, follow-up in six weeks only: ignores the immediate danger.

Final Answer: Treat the overdose with a self-harm risk assessment ⇒ B

Answer: (B) Go Back to Q14

Q15.

Solution

Concept – dissociative fugue: Dissociative fugue combines dissociative amnesia with unexpected travel.

Step 1 – read the features: Purposeful **travel away from home** with loss of memory for identity and the recent past, after a **severe stressor** and without an organic cause, defines dissociative fugue.

Step 2 – the relationship to amnesia: Dissociative amnesia is the loss of important personal memories; when it is accompanied by wandering with a new or lost identity, it is termed a fugue.

Why the other options are wrong:

- A, delirium: has clouded consciousness and fluctuating attention, absent here.
- C, malingering: is conscious feigning for external gain, not the picture described.
- D, transient global amnesia: is a brief, self-limited amnesia without purposeful travel or an identity change.

Final Answer: Dissociative fugue $\Rightarrow$ $\boxed{\text{B}}$

Answer: (B) Go Back to Q15

Answer Key

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