INI CET Psychiatry

Sample Paper – 6

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 has four days of persistently elevated mood, increased energy, talkativeness and a reduced need for sleep, but continues to work and function, with no psychotic features and no need for hospital admission. Compared with a full manic episode, this hypomanic presentation is best distinguished by:

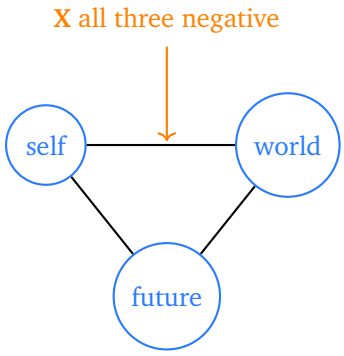
(A) The absence of psychosis and of marked functional impairment, whereas mania may carry psychotic features and causes marked impairment or hospitalisation

(B) The invariable presence of delusions and hallucinations

(C) A longer minimum duration than a manic episode

(D) Being identical to mania in severity, duration and outcome

Q2. The schematic below depicts Beck's cognitive triad (marked **X**), the three linked negative appraisals that maintain a depressive episode. These three appraisals are directed at:



(A) Elevated self-esteem, an optimistic world view and hopeful expectations

(B) Persecutory beliefs about others, the world and external agencies

(C) Negative views of the self, the world and the future

(D) Somatic preoccupations with the body, illness and impending death

Q3. A man is trapped briefly in a minor road accident and within an hour becomes dazed, anxious and tremulous, with the symptoms settling over the next two days. His neighbour, months after a separate assault, still has intrusive flashbacks, nightmares and hypervigilance. The timing that separates an acute stress reaction from post-traumatic stress disorder (PTSD) is best stated as:

(A) Both conditions can be diagnosed only after six months have elapsed

(B) PTSD is diagnosed when symptoms persist beyond one month after the trauma, whereas an acute stress reaction begins within minutes to hours and settles within a few days

(C) An acute stress reaction, by definition, lasts longer than PTSD

(D) PTSD begins within hours of the event and clears within two days

Psychotic Disorders

Q4. On phenomenological examination, a delusion is judged to be 'primary' rather than 'secondary'. The correct distinction between a primary and a secondary delusion is:

(A) A primary delusion arises suddenly and fully formed, and cannot be understood from any preceding experience, whereas a secondary delusion develops understandably out of another morbid experience such as low mood or a hallucination

(B) A primary delusion always develops out of a preceding hallucination or mood change

(C) Secondary delusions are, by definition, bizarre and untreatable

(D) There is no clinical or phenomenological difference between the two

Q5. A patient with schizophrenia reports hearing a voice repeatedly ordering him to harm a family member. In assessing these command hallucinations, the most appropriate understanding is that:

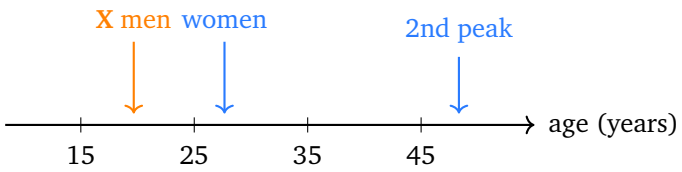
(A) They are always harmless and need no formal risk assessment

(B) They are auditory hallucinations that instruct the patient to act, and they carry a raised risk of harm to self or others, so their content and the patient's likelihood of acting on them must be assessed carefully

(C) They are visual hallucinations of commanding figures

(D) They confirm a diagnosis of delusional disorder rather than schizophrenia

Q6. The age axis below (marked **X**) compares the typical age of first onset of schizophrenia in men and in women. The pattern is best described as:



(A) Both men and women develop it only after the age of 45

(B) Women develop it earlier than men, in early adolescence

(C) Onset is identical in both sexes at around the age of 40

(D) Men typically present earlier (late teens to mid-20s) while women present later (late 20s), with a second peak in women after 45

Substance Use and Organic Disorders

Q7. A 40-year-old man who smokes 25 cigarettes a day wants to quit and asks about medicines that improve his chances. The evidence-based first-line pharmacotherapies for nicotine dependence are:

(A) Only nicotine replacement therapy has any supporting evidence

(B) Disulfiram, given as it is for alcohol dependence

(C) Naltrexone as the single drug of choice

(D) Varenicline, bupropion and nicotine replacement therapy, all of which are effective evidence-based options

Q8. A 72-year-old man has a cognitive decline with day-to-day fluctuation in attention, recurrent well-formed visual hallucinations, spontaneous parkinsonism and a severe adverse reaction when given an antipsychotic. The most likely diagnosis is:

(A) Alzheimer's disease

(B) Dementia with Lewy bodies

(C) Vascular dementia

(D) Frontotemporal dementia

Child, Neurodevelopmental and Personality Disorders

Q9. A 6-year-old girl talks freely and normally at home with her parents, but has consistently failed to speak at school for more than a month, despite having intact language ability and normal hearing. The diagnosis is:

(A) Autism spectrum disorder

(B) Intellectual disability

(C) Selective mutism

(D) Expressive language disorder

Q10. A girl develops normally for her first six months, then shows a deceleration of head growth, loss of previously acquired purposeful hand skills with stereotypic hand-wringing movements, and regression of language and social engagement. This specific neurodevelopmental regression is:

(A) Rett syndrome

(B) Autism spectrum disorder

(C) Attention-deficit hyperactivity disorder

(D) Down syndrome

Q11. A young man avoids work assignments and social gatherings because he is terrified of criticism and rejection, feels socially inept and inferior, and will mix only if he is certain of being liked. This pattern indicates which personality disorder?

(A) Schizoid personality disorder

(B) Borderline (emotionally unstable) personality disorder

(C) Dependent personality disorder

(D) Avoidant (anxious) personality disorder

Psychopharmacology and Therapeutics

Q12. A patient on an antidepressant eats a large portion of mature cheese and cured meat and, soon afterwards, develops a throbbing headache, palpitations and a dangerously high blood pressure. This tyramine ('cheese') reaction and hypertensive crisis points to which class of drug?

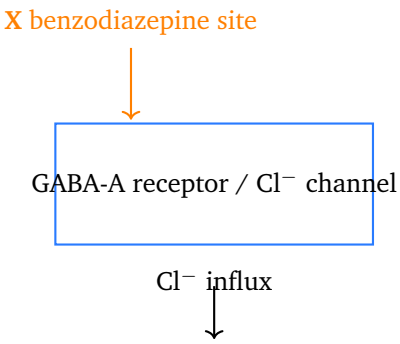
(A) Monoamine oxidase inhibitors, which can precipitate a hypertensive crisis when combined with tyramine-rich foods

(B) Selective serotonin reuptake inhibitors

(C) Benzodiazepines

(D) Lithium carbonate

Q13. The schematic below shows a benzodiazepine binding at its site on the GABA-A receptor chloride channel (marked **X**). Regarding this drug class, the correct statement about mechanism, dependence and reversal is:



(A) They block dopamine D2 receptors and are reversed by naloxone

(B) They enhance GABA-A receptor chloride-channel opening, can cause tolerance and dependence, and are reversed by the antagonist flumazenil

(C) They are serotonin reuptake inhibitors reversed by cyproheptadine

(D) They block NMDA receptors and have no specific antidote

Emergency Psychiatry and Miscellaneous

Q14. A floridly psychotic patient refuses admission but poses a clear danger to himself and cannot appreciate the need for treatment. The legal and ethical basis for an involuntary (compulsory) admission is best summarised as:

(A) The patient's own written request alone is enough

(B) The family's convenience is the deciding factor

(C) The presence of a mental disorder with a significant risk to the patient's own safety or that of others, when the patient lacks the capacity to consent, using the least restrictive option available

(D) A raised inflammatory marker on blood testing

Q15. Two patients each produce false illness. One repeatedly fakes symptoms and even injures himself to be admitted and cared for, with no material reward in view; the other feigns back pain purely to claim insurance money. The correct distinction between factitious disorder and malingering is:

(A) In factitious disorder the symptoms are unconscious, while in malingering they are genuine

(B) Both are motivated principally by an external reward

(C) In factitious disorder symptoms are intentionally produced to assume the sick role with no external incentive, whereas in malingering symptoms are feigned for an external gain such as money or avoiding work

(D) Malingering is a formal psychiatric diagnosis whereas factitious disorder is not recognised

Detailed Solutions

Q1.

Solution

Concept – hypomania versus mania: Both lie on the manic pole of bipolar disorder, but they differ in severity, duration and consequences.

Step 1 – read the vignette: Elevated mood, increased energy and a reduced need for sleep are present, yet the patient keeps working, has *no psychosis* and needs *no admission*.

Step 2 – apply the distinguishing rule: Hypomania is milder and shorter, with **no psychotic features and no marked functional impairment**; full mania lasts at least a week (or needs admission) and may include psychosis with marked impairment.

Why the other options are wrong:

- B, invariable delusions and hallucinations: psychosis excludes hypomania and points to mania.
- C, a longer duration: hypomania is the *shorter* state (at least four days versus at least a week).
- D, identical to mania: this denies the very distinction being tested.

Final Answer: No psychosis and no marked functional impairment $\Rightarrow$ $\boxed{\text{A}}$

Answer: (A) Go Back to Q1

Q2.

Solution

Concept – Beck's cognitive triad: Beck proposed that depression is maintained by three linked negative cognitions.

Step 1 – read the schematic: The three connected circles (marked **X**) are the self, the world and the future, all appraised negatively.

Step 2 – name the triad: The cognitive triad is a **negative view of the self** (worthless), a **negative view of the world** (hostile, defeating) and a **negative view of the future** (hopeless).

Why the other options are wrong:

- A, elevated self-esteem and optimism: describe the opposite, manic, cognition.

- B, persecutory beliefs: describe paranoid thinking, not the depressive triad.
- D, somatic preoccupations: describe hypochondriasis, not Beck's triad.

Final Answer: Negative views of the self, the world and the future ⇒ C

Answer: (C) Go Back to Q2

Q3.

Solution

Concept – acute stress reaction versus PTSD: Both follow a traumatic event, but the *timing* of onset and duration separates them.

Step 1 – read the two courses: The trapped man's dazed, anxious state begins within an hour and settles in two days; the neighbour's flashbacks and hypervigilance persist for months.

Step 2 – apply the timing rule: An **acute stress reaction** begins within minutes to hours of the stressor and resolves within a few days. **PTSD** is diagnosed when the intrusive, avoidant and hyperarousal symptoms **persist beyond one month**.

Why the other options are wrong:

- A, only after six months: this describes delayed-onset PTSD, not the routine distinction.
- C, acute reaction lasting longer than PTSD: reverses the true durations.
- D, PTSD clearing within two days: that transient course is the acute stress reaction, not PTSD.

Final Answer: PTSD persists beyond one month; acute stress reaction settles within days ⇒ B

Answer: (B) Go Back to Q3

Q4.

Solution

Concept – primary versus secondary delusion: This is a core phenomenology distinction based on how the belief arises.

Step 1 – define a primary delusion: A **primary (autochthonous) delusion** appears suddenly, fully formed, and is *not understandable* from any preceding mood, perception or experience.

Step 2 – define a secondary delusion: A **secondary delusion** arises *understand-*

ably out of another morbid experience, such as low mood (mood-congruent guilt) or a hallucination.

Why the other options are wrong:

- B, a primary delusion developing from a hallucination: that describes a *secondary* delusion.
- C, secondary delusions being bizarre and untreatable: bizarreness and treatability are not the defining feature.
- D, no difference: the whole distinction rests on understandability of origin.

Final Answer: Primary arises un-understandably; secondary arises from another experience $\Rightarrow$ A

Answer: (A) Go Back to Q4

Q5.

Solution

Concept – command hallucinations: These are auditory hallucinations that instruct the patient to perform an act.

Step 1 – read the risk: When the voice orders harm to a family member, the content directs potential violence, so command hallucinations **raise the risk of harm to self or others**.

Step 2 – the assessment: Assess the **content** of the commands and the patient's **likelihood of acting** on them (past compliance, identity of the voice, insight), and manage accordingly.

Why the other options are wrong:

- A, always harmless: dangerously false; they mandate careful assessment.
- C, visual hallucinations: command hallucinations are auditory.
- D, confirming delusional disorder: they occur in schizophrenia; delusional disorder characteristically lacks prominent hallucinations.

Final Answer: Voices instructing action that raise risk and must be assessed $\Rightarrow$ B

Answer: (B) Go Back to Q5

Q6.

Solution

Concept – age of onset of schizophrenia by sex: Onset differs between men and women in a well-recognised pattern.

Step 1 – read the age axis: The orange marker (**X**) for men sits earlier than the marker for women, with a later second peak in women.

Step 2 – state the pattern: Men typically present **earlier, in the late teens to mid-20s**; women present **later, in the late 20s**, with a **second peak after age 45** (linked to falling oestrogen).

Why the other options are wrong:

- A, both only after 45: far too late for the usual first onset.
- B, women earlier than men: reverses the true pattern.
- C, identical onset at 40: ignores the sex difference and is too late.

Final Answer: Men earlier, women later with a second peak after 45 $\Rightarrow$ $\boxed{\text{D}}$

Answer: (D) Go Back to Q6

Q7.

Solution

Concept – pharmacotherapy for smoking cessation: Nicotine dependence has three established first-line drug treatments.

Step 1 – list the options: Varenicline (a partial nicotinic agonist), **bupropion** (an antidepressant that reduces craving) and **nicotine replacement therapy** (patch, gum, lozenge) are all effective and evidence-based.

Step 2 – combine with support: Each works best alongside behavioural counselling and a set quit date.

Why the other options are wrong:

- A, only NRT has evidence: varenicline and bupropion are also proven.
- B, disulfiram: is used for alcohol, not nicotine, dependence.
- C, naltrexone: is used mainly for alcohol and opioid dependence, not as the drug of choice for smoking.

Final Answer: Varenicline, bupropion and nicotine replacement therapy $\Rightarrow$ $\boxed{\text{D}}$

Answer: (D) Go Back to Q7

Q8.

Solution

Concept – dementia with Lewy bodies: This is a common neurodegenerative dementia with a distinctive core cluster.

Step 1 – match the core features: Fluctuating cognition, **recurrent well-formed visual hallucinations** and spontaneous **parkinsonism** are the core diagnostic triad.

Step 2 – note the drug warning: Marked **neuroleptic (antipsychotic) sensitivity**, with severe reactions to dopamine blockers, is a supportive hallmark, so antipsychotics must be used with great caution.

Why the other options are wrong:

- A, Alzheimer's disease: has an insidious amnestic decline without prominent early hallucinations or parkinsonism.
- C, vascular dementia: shows a stepwise decline with focal neurological signs.
- D, frontotemporal dementia: presents with early personality change or language decline, not this triad.

Final Answer: Dementia with Lewy bodies $\Rightarrow$ $\boxed{\text{B}}$

Answer: (B) Go Back to Q8

Q9.

Solution

Concept – selective mutism: Selective mutism is a childhood anxiety-related disorder of speaking.

Step 1 – read the pattern: The child **speaks normally at home** but **consistently fails to speak in specific social settings** (here, school) for more than a month.

Step 2 – confirm the intact abilities: Language ability and hearing are normal, so the silence is situational, not a language or hearing deficit.

Why the other options are wrong:

- A, autism: would show pervasive social-communication deficits across all settings, not selective silence.
- B, intellectual disability: is a global cognitive deficit, absent here.
- D, expressive language disorder: impairs language ability itself, which is intact in this child.

Final Answer: Selective mutism ⇒ C

Answer: (C) Go Back to Q9

Q10.

Solution

Concept – Rett syndrome: Rett syndrome is a specific neurodevelopmental regression, almost exclusively in girls.

Step 1 – read the course: Normal early development, then **deceleration of head growth**, **loss of purposeful hand use** with stereotypic hand-wringing, and regression of language and social skills.

Step 2 – the basis: It is usually caused by a mutation in the *MECP2* gene on the X chromosome.

Why the other options are wrong:

- B, autism: lacks the characteristic head-growth deceleration and hand-wringing regression.
- C, ADHD: is inattention and hyperactivity, with no regression of acquired skills.
- D, Down syndrome: is a chromosomal condition present from birth, not a regression after normal development.

Final Answer: Rett syndrome ⇒ A

Answer: (A) Go Back to Q10

Q11.

Solution

Concept – avoidant (anxious) personality disorder: This disorder centres on social inhibition driven by fear of criticism.

Step 1 – match the pattern: Social inhibition, feelings of **inadequacy and inferiority**, hypersensitivity to **criticism and rejection**, and mixing only when sure of being liked, define avoidant personality disorder.

Step 2 – the key wish: Unlike the schizoid patient, the avoidant patient *wants* relationships but avoids them out of fear.

Why the other options are wrong:

- A, schizoid: is genuine emotional detachment and a preference for solitude, without the fear of criticism.
- B, borderline: is affective instability, impulsivity and fear of abandonment, not core social inhibition.
- C, dependent: is an excessive need to be looked after, not avoidance driven by fear of criticism.

Final Answer: Avoidant (anxious) personality disorder $\Rightarrow$ D

Answer: (D) Go Back to Q11

Q12.

Solution

Concept – monoamine oxidase inhibitors (MAOIs) and tyramine: MAOIs block the breakdown of monoamines, including dietary tyramine.

Step 1 – read the reaction: Eating **tyramine-rich food** (mature cheese, cured meat) while on an MAOI lets absorbed tyramine release stored noradrenaline, causing a throbbing headache, palpitations and a **hypertensive crisis** (the 'cheese reaction').

Step 2 – the advice: Patients on MAOIs must avoid tyramine-rich foods and certain sympathomimetic drugs.

Why the other options are wrong:

- B, SSRIs: do not cause a tyramine reaction; their concern is serotonin syndrome.
- C, benzodiazepines: are anxiolytics with no tyramine interaction.
- D, lithium: is a mood stabiliser monitored for its narrow index, not for tyramine.

Final Answer: Monoamine oxidase inhibitors $\Rightarrow$ A

Answer: (A) Go Back to Q12

Q13.

Solution

Concept – benzodiazepines at the GABA-A receptor: Benzodiazepines act through the brain's main inhibitory receptor.

Step 1 – read the mechanism: They bind a specific site on the **GABA-A receptor** (marked **X**) and **enhance chloride-channel opening** in the presence of GABA, increasing inhibition.

Step 2 – dependence and reversal: Long-term use causes **tolerance and dependence**, and overdose can be reversed by the competitive antagonist **flumazenil**.

Why the other options are wrong:

- A, D2 blockade reversed by naloxone: describes neither the mechanism nor the antidote (naloxone reverses opioids).
- C, serotonin reuptake inhibition: is the action of SSRIs, not benzodiazepines.
- D, NMDA blockade with no antidote: is wrong on both mechanism and reversal.

Final Answer: Enhance GABA-A chloride opening; dependence; reversed by flumazenil $\Rightarrow$ B

Answer: (B) Go Back to Q13

Q14.

Solution

Concept – involuntary admission and capacity: Compulsory admission balances the patient's autonomy against safety.

Step 1 – read the justification: It requires a **mental disorder** with a **significant risk** to the patient's own safety or to others, *and* the patient **lacks the capacity** to make an informed treatment decision.

Step 2 – the guiding principle: The **least restrictive** option that manages the risk should be chosen, and the process must follow the relevant mental-health law.

Why the other options are wrong:

- A, the patient's own written request: that would be a *voluntary* admission.
- B, family convenience: is never a lawful basis for compulsory detention.
- D, a raised inflammatory marker: is irrelevant to the legal test for admission.

Final Answer: Mental disorder plus risk plus lack of capacity, least restrictive $\Rightarrow$

C

Answer: (C) Go Back to Q14

Q15.

Solution

Concept – factitious disorder versus malingering: Both involve deliberately produced illness, but they differ in the underlying motive.

Step 1 – factitious disorder: Symptoms are **intentionally produced** (even self-injury) to **assume the sick role**, with *no external incentive*; this is a psychiatric diagnosis (Munchausen at its extreme).

Step 2 – malingering: Symptoms are **feigned for an external gain** such as money, drugs or avoiding work; malingering is *not* a psychiatric disorder but a behaviour.

Why the other options are wrong:

- A, factitious symptoms being unconscious: in both, the production is conscious and intentional.
- B, both driven by external reward: only malingering has an external incentive.
- D, malingering being a formal diagnosis while factitious is not: this reverses the truth.

Final Answer: Factitious for the sick role (no external gain); malingering for external gain $\Rightarrow$ C

Answer: (C) Go Back to Q15

Answer Key

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