INI CET Psychiatry

Sample Paper – 7

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 48-year-old man has three weeks of profoundly depressed mood, anhedonia and psychomotor retardation. He is now convinced that his internal organs have rotted away and that he deserves to be punished for ruining his family. There are no other perceptual disturbances. This presentation is best classified as:

(A) A severe depressive episode with mood-congruent psychotic features

(B) A manic episode with psychotic features

(C) Schizophrenia, paranoid type

(D) Generalised anxiety disorder

Q2. A patient has fully recovered from her third distinct episode of major depression, with complete remission between episodes and no history of mania. Regarding relapse prevention in recurrent depressive disorder, the most appropriate advice is:

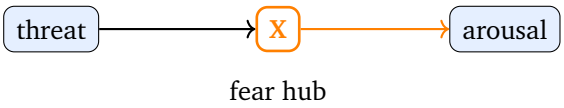
(A) Continue the effective antidepressant as long-term maintenance because the recurrence risk is high

(B) Stop the antidepressant immediately once remission is achieved

(C) Switch to a mood stabiliser as monotherapy for life

(D) Reduce the dose below the effective range to limit side effects

Q3. The schematic below traces the rapid fear response: a threatening stimulus reaches a brain structure (marked **X**) that then drives autonomic arousal, freezing and the release of stress hormones. This central hub of the fear circuit is the:



fear hub

(A) Cerebellum

(B) Amygdala

(C) Occipital cortex

(D) Basal ganglia

Psychotic Disorders

Q4. A man treated for schizophrenia five years ago no longer has delusions or hallucinations, but shows persistent social withdrawal, poverty of speech, blunted affect and marked lack of drive. This clinical picture represents the:

(A) Acute (active) phase of schizophrenia

(B) Prodromal phase preceding a first episode

(C) Residual phase of schizophrenia

(D) Complete recovery with no residual symptoms

Q5. Which of the following most accurately distinguishes a **bizarre** delusion from a **non-bizarre** delusion?

(A) A bizarre delusion is always held with less conviction

(B) A bizarre delusion is clearly implausible and impossible within the person's culture, whereas a non-bizarre delusion could conceivably occur in real life

(C) A non-bizarre delusion is always accompanied by hallucinations

(D) A bizarre delusion resolves without treatment

Q6. A patient describes hearing an inner voice 'inside my head' that she recognises is a product of her own mind, experienced in inner subjective space and lacking the vivid external reality of a true hallucination. This phenomenon is termed a:

(A) Second-person auditory hallucination

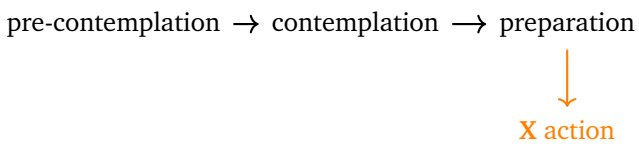
(B) Delusional perception

(C) Thought echo

(D) Pseudohallucination

Substance Use and Organic Disorders

Q7. The cycle below shows the stages a person moves through when changing an addictive behaviour, ending at the point (marked **X**) where the individual takes active steps and modifies the behaviour. In the transtheoretical (readiness to change) model, this stage is:



(A) Pre-contemplation

(B) Contemplation

(C) Preparation

(D) Action

Q8. A 70-year-old with suspected cognitive decline scores 19 out of 30 on the Mini-Mental State Examination (MMSE). This instrument mainly assesses cognition, and a score in this range is best interpreted as:

(A) Cognitive impairment, warranting further evaluation for dementia

(B) Entirely normal cognition

(C) A measure of depression severity, not cognition

(D) A measure of psychotic symptom severity

Child, Neurodevelopmental and Personality Disorders

Q9. A 4-year-old raised in a series of neglectful placements shows persistent emotional withdrawal, rarely seeks or responds to comfort when distressed, and displays minimal social and emotional responsiveness to carers. The most likely diagnosis is:

(A) Autism spectrum disorder

(B) Reactive attachment disorder

(C) Attention-deficit hyperactivity disorder

(D) Intellectual disability

Q10. Both autism and the classic Asperger presentation share social-communication difficulties and restricted interests. The feature that traditionally distinguishes the Asperger presentation from autism is:

(A) No clinically significant delay in early language milestones

(B) Absence of any restricted or repetitive interests

(C) Onset only in adulthood

(D) Presence of hallucinations from early childhood

Q11. A man interprets ordinary remarks and events as demeaning or threatening, bears persistent grudges, doubts the loyalty of friends and is reluctant to confide for fear the information will be used against him. This enduring pattern indicates which personality disorder?

(A) Schizoid personality disorder

(B) Histrionic personality disorder

(C) Paranoid personality disorder

(D) Dependent personality disorder

Psychopharmacology and Therapeutics

Q12. A patient who abruptly stops a short-half-life SSRI develops, within a couple of days, dizziness, 'electric-shock' sensations, nausea, insomnia and flu-like symptoms that settle when the drug is restarted. This is best described as:

(A) Serotonin syndrome

(B) SSRI discontinuation (withdrawal) syndrome

(C) A relapse of the original depression

(D) Neuroleptic malignant syndrome

Q13. The antipsychotic effect of these drugs is attributed mainly to blockade of a particular dopamine receptor. This receptor, and the property that broadly separates atypical from typical antipsychotics, are:

(A) D1 blockade; atypicals have stronger D1 action

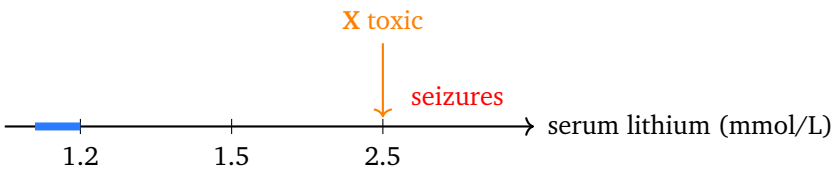
(B) Muscarinic blockade; typicals spare acetylcholine

(C) D2 blockade; typicals additionally block serotonin (5-HT2) heavily

(D) D2 blockade; atypicals have relatively lower D2 occupancy with added 5-HT2 antagonism and fewer extrapyramidal effects

Emergency Psychiatry and Miscellaneous

Q14. The scale below plots rising serum lithium; at the level marked **X** the patient develops coarse tremor, ataxia, drowsiness, vomiting and seizures. The correct recognition and the definitive treatment of this state are:



(A) Serotonin syndrome; treat with cyproheptadine

(B) Simple fine tremor; reassure and continue the dose

(C) Lithium toxicity; stop lithium, give intravenous fluids and use haemodialysis in severe cases

(D) Neuroleptic malignant syndrome; give dantrolene

Q15. A psychiatrist offers a structured, time-limited therapy that helps a patient identify and challenge distorted automatic thoughts and change unhelpful behaviours, and is a first-line treatment for depression and anxiety disorders. This therapy is:

(A) Classical psychoanalysis

(B) Electroconvulsive therapy

(C) Cognitive behavioural therapy

(D) Systemic family therapy

Detailed Solutions

Q1.

Solution

Concept – depression with psychotic features: A severe depressive episode can carry delusions or hallucinations, and these are usually *mood-congruent*.

Step 1 – read the mood: Three weeks of profound depressed mood, anhedonia and psychomotor retardation establish a severe depressive episode.

Step 2 – identify the psychosis: Nihilistic delusions (organs rotting away) and delusions of guilt and deserved punishment are **mood-congruent** to the depressed state.

Why the other options are wrong:

- B, mania with psychosis: requires elated or irritable mood and overactivity, which are absent.
- C, paranoid schizophrenia: the delusions here arise from and match the mood, and there is no primary thought disorder.
- D, generalised anxiety: is chronic worry without psychotic delusions.

Final Answer: Severe depression with mood-congruent psychotic features $\Rightarrow$ A

Answer: (A) Go Back to Q1

Q2.

Solution

Concept – relapse prevention in recurrent depression: Each further episode raises the risk of another, so maintenance treatment matters.

Step 1 – weigh the history: Three distinct episodes place this patient at **high recurrence risk**, the threshold at which long-term prophylaxis is advised.

Step 2 – the recommendation: Continue the effective antidepressant at the treatment dose for prolonged maintenance, alongside relapse-prevention psychotherapy.

Why the other options are wrong:

- B, stop immediately: sharply increases the chance of relapse.
- C, mood stabiliser monotherapy: is reserved for bipolar disorder, which is absent here.
- D, sub-therapeutic dose: loses efficacy while retaining side effects.

Final Answer: Continue the effective antidepressant as maintenance ⇒ A

Answer: (A) Go Back to Q2

Q3.

Solution

Concept – the amygdala and the fear response: The amygdala is the central hub that appraises threat and triggers the fear reaction.

Step 1 – read the schematic: A threat signal reaches the structure marked **X**, which then drives autonomic arousal, freezing and stress-hormone release.

Step 2 – name the hub: This is the **amygdala**, which rapidly evaluates danger and activates the hypothalamic and brainstem outputs of the fear circuit; it is overactive in anxiety disorders.

Why the other options are wrong:

- A, cerebellum: coordinates movement and balance.
- C, occipital cortex: processes vision, not fear appraisal.
- D, basal ganglia: regulate movement and habit, not the core fear response.

Final Answer: Amygdala ⇒ B

Answer: (B) Go Back to Q3

Q4.

Solution

Concept – the residual phase of schizophrenia: Schizophrenia often leaves persistent negative symptoms after the acute psychosis has settled.

Step 1 – note the absence of positive symptoms: There are no current delusions or hallucinations, so the active (acute) phase has passed.

Step 2 – recognise the residuum: Social withdrawal, poverty of speech, blunted affect and avolition persisting after the active phase define the **residual phase**.

Why the other options are wrong:

- A, acute phase: is dominated by florid positive symptoms.
- B, prodrome: precedes the first episode, whereas this follows a treated episode.

- D, complete recovery: is excluded by the persistent negative symptoms.

Final Answer: Residual phase of schizophrenia $\Rightarrow$ C

Answer: (C) Go Back to Q4

Q5.

Solution

Concept – bizarre versus non-bizarre delusions: The distinction rests on plausibility, not on conviction.

Step 1 – define bizarre: A **bizarre** delusion is clearly implausible and physically impossible within the person's culture (for example, that aliens removed one's brain).

Step 2 – define non-bizarre: A **non-bizarre** delusion involves a situation that could conceivably occur in real life (for example, being followed or poisoned).

Why the other options are wrong:

- A, conviction: both types are held with fixed conviction.
- C, hallucinations: non-bizarre delusions need not have hallucinations.
- D, resolves untreated: bizarre delusions do not spontaneously resolve.

Final Answer: Bizarre is impossible within the culture; non-bizarre could occur in real life $\Rightarrow$ B

Answer: (B) Go Back to Q5

Q6.

Solution

Concept – pseudohallucination: A pseudohallucination is perceived in inner subjective space and recognised as unreal.

Step 1 – read the features: The voice is experienced **'inside the head'**, in inner subjective space, and the patient **knows it is a product of her own mind**.

Step 2 – contrast with a true hallucination: A true hallucination is vivid, located in external objective space and experienced as real perception without insight.

Why the other options are wrong:

- A, second-person hallucination: is a true perception in external space, held with no insight.

- B, delusional perception: is a real perception given a delusional meaning.
- C, thought echo: is hearing one's own thoughts spoken aloud, a first-rank symptom.

Final Answer: Pseudohallucination $\Rightarrow$ D

Answer: (D) Go Back to Q6

Q7.

Solution

Concept – the transtheoretical (stages of change) model: Prochaska and DiClemente described sequential stages of readiness to change.

Step 1 – read the cycle: The stages run pre-contemplation, contemplation, preparation and then the point marked **X** where the person actively modifies the behaviour.

Step 2 – name the stage: Actively taking steps and changing the behaviour is the **action** stage, followed later by maintenance.

Why the other options are wrong:

- A, pre-contemplation: the person does not yet intend to change.
- B, contemplation: the person is only weighing up change.
- C, preparation: the person plans and gets ready but has not yet acted.

Final Answer: Action stage $\Rightarrow$ D

Answer: (D) Go Back to Q7

Q8.

Solution

Concept – the Mini-Mental State Examination (MMSE): The MMSE is a 30-point bedside test of cognition.

Step 1 – recall the domains: It samples orientation, registration, attention and calculation, recall, language and construction.

Step 2 – interpret the score: A score of **19 of 30** falls below the usual normal cut-off (about 24), indicating **cognitive impairment** that warrants further assessment for dementia.

Why the other options are wrong:

- B, normal: is incorrect because the score is well below the cutoff.
- C, depression severity: the MMSE tests cognition, not mood.
- D, psychosis severity: it does not measure psychotic symptoms.

Final Answer: Cognitive impairment, evaluate for dementia ⇒ A

Answer: (A) Go Back to Q8

Q9.

Solution

Concept – reactive attachment disorder: This is a disorder of early childhood arising from grossly insufficient care.

Step 1 – read the history: Repeated neglectful placements provide the required background of pathogenic care.

Step 2 – match the signs: Persistent emotional withdrawal, rarely seeking or responding to comfort, and minimal social and emotional responsiveness define reactive attachment disorder.

Why the other options are wrong:

- A, autism: has pervasive social-communication deficits regardless of care, plus repetitive behaviours.
- C, ADHD: is inattention and hyperactivity, not withdrawal from comfort.
- D, intellectual disability: is defined by low IQ and adaptive deficits.

Final Answer: Reactive attachment disorder ⇒ B

Answer: (B) Go Back to Q9

Q10.

Solution

Concept – autism versus the Asperger presentation: Both share the social-communication and repetitive-behaviour domains.

Step 1 – find the discriminator: The traditional distinction is that the Asperger presentation shows **no clinically significant delay in early language milestones**, whereas classic autism often does.

Step 2 – add the context: Cognitive development is likewise preserved in the Asperger presentation.

Why the other options are wrong:

- B, no restricted interests: restricted interests are actually present in Asperger presentations.
- C, adult onset: both are neurodevelopmental with early-childhood onset.
- D, hallucinations: are not a feature of either condition.

Final Answer: No significant early language delay ⇒ A

Answer: (A) Go Back to Q10

Q11.

Solution

Concept – paranoid personality disorder: This is an enduring pattern of pervasive distrust and suspiciousness.

Step 1 – match the pattern: Reading demeaning or threatening meaning into ordinary remarks, bearing grudges, doubting others' loyalty and reluctance to confide define paranoid personality disorder.

Step 2 – the qualifier: It is a long-standing trait pattern, not an episodic psychotic illness, and reality testing is broadly preserved.

Why the other options are wrong:

- A, schizoid: is emotional detachment and preference for solitude, without suspiciousness.
- B, histrionic: is attention-seeking and shallow emotionality.
- D, dependent: is clinging and an excessive need to be cared for.

Final Answer: Paranoid personality disorder ⇒ C

Answer: (C) Go Back to Q11

Q12.

Solution

Concept – SSRI discontinuation syndrome: Abruptly stopping an SSRI, especially one with a short half-life, can provoke withdrawal symptoms.

Step 1 – read the timing and drug: Symptoms begin within a day or two of **stopping a short-half-life SSRI**.

Step 2 – match the symptoms: Dizziness, 'electric-shock' sensations, nausea,

insomnia and flu-like symptoms that settle on restarting the drug define the discontinuation syndrome.

Why the other options are wrong:

- A, serotonin syndrome: follows serotonergic *excess*, with hyperthermia and clonus, not withdrawal.
- C, relapse: would emerge gradually over weeks, not abruptly with these somatic features.
- D, NMS: follows dopamine blockers, with rigidity and fever.

Final Answer: SSRI discontinuation (withdrawal) syndrome $\Rightarrow$ B

Answer: (B) Go Back to Q12

Q13.

Solution

Concept – antipsychotic mechanism and drug classes: Antipsychotic action rests chiefly on dopamine D2 receptor blockade.

Step 1 – name the receptor: The therapeutic effect is attributed mainly to **D2 blockade** in the mesolimbic pathway.

Step 2 – separate the classes: **Atypical** agents combine relatively **lower D2 occupancy with 5-HT2 antagonism**, giving **fewer extrapyramidal effects** than typical agents.

Why the other options are wrong:

- A, D1 emphasis: is not the basis of the class distinction.
- B, muscarinic blockade: explains anticholinergic side effects, not the antipsychotic effect.
- C, typicals blocking 5-HT2 heavily: it is the atypicals, not typicals, that add strong 5-HT2 antagonism.

Final Answer: D2 blockade; atypicals add 5-HT2 antagonism with fewer extrapyramidal effects $\Rightarrow$ D

Answer: (D) Go Back to Q13

Q14.

Solution

Concept – lithium toxicity: Lithium has a narrow therapeutic index, so levels above about 1.5 mmol/L become toxic.

Step 1 – read the scale: At the level marked **X** the patient shows **coarse tremor, ataxia, drowsiness, vomiting and seizures**, the picture of lithium toxicity.

Step 2 – manage it: Stop lithium, give intravenous fluids to restore volume and enhance excretion, and use **haemodialysis** in severe toxicity (marked neurological signs, very high levels or renal impairment).

Why the other options are wrong:

- A, serotonin syndrome: follows serotonergic drugs and is not treated by dialysis.
- B, simple fine tremor: a fine tremor is benign, but coarse tremor with ataxia and seizures signals toxicity.
- D, NMS: follows antipsychotics; dantrolene does not treat lithium toxicity.

Final Answer: Lithium toxicity; stop lithium, give fluids, dialyse if severe $\Rightarrow$ $\boxed{\text{C}}$

Answer: (C) Go Back to Q14

Q15.

Solution

Concept – cognitive behavioural therapy (CBT): CBT is a structured, time-limited talking therapy linking thoughts, feelings and behaviour.

Step 1 – read the description: The therapy **identifies and challenges distorted automatic thoughts** and changes unhelpful behaviours over a limited number of sessions.

Step 2 – recall the indications: CBT is a **first-line** treatment for depression and for anxiety disorders, and is used in OCD, PTSD and many other conditions.

Why the other options are wrong:

- A, psychoanalysis: is long-term and explores unconscious conflict, not structured thought records.
- B, ECT: is a physical treatment for severe depression, not a talking therapy.
- D, family therapy: works with family systems rather than individual automatic thoughts.

Final Answer: Cognitive behavioural therapy $\Rightarrow$ C

Answer: (C) Go Back to Q15

Answer Key

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