INI CET Psychiatry

Sample Paper – 8

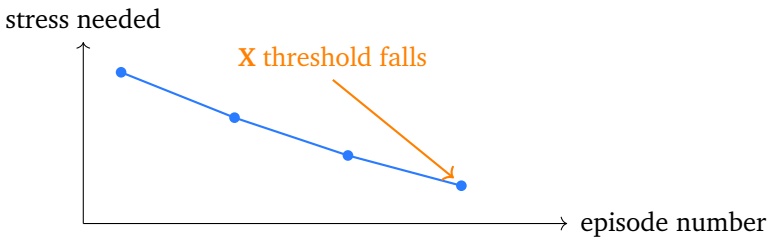
Duration: 14 Minutes **Maximum Marks: 15**

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. The schematic below shows successive affective episodes in bipolar disorder, each triggered by a progressively smaller stress (marked **X**) until episodes arise almost on their own. This biological model, in which repeated episodes lower the threshold for future ones, is called the:



(A) The dopamine over-activity hypothesis

(B) The monoamine depletion hypothesis

(C) The kindling (sensitisation) hypothesis

(D) The dexamethasone suppression hypothesis

Q2. A 34-year-old man repeatedly attends casualty with palpitations, chest tightness, breathlessness and a conviction that he is having a heart attack; investigations are normal, yet he remains preoccupied that he has serious heart disease between attacks. The picture illustrating the overlap of panic-type somatic symptoms with persistent health anxiety is best explained as:

(A) A purely cardiac illness that has been missed

(B) A factitious disorder with deliberately feigned symptoms

(C) Panic attacks driving, and reinforcing, an illness-anxiety (health-anxiety) preoccupation

(D) Malingering for external gain

Q3. A patient shows loss of the capacity to feel pleasure, along with a separate loss of drive and initiation of activity. Which pairing correctly defines these terms?

(A) Anhedonia is loss of will; abulia is loss of pleasure

(B) Anhedonia is loss of pleasure; apathy is loss of feeling or motivation; abulia is loss of will or drive

(C) Apathy is loss of pleasure; anhedonia is elevated mood

(D) Abulia is excessive activity; apathy is loss of pleasure

Psychotic Disorders

Q4. A young man with schizophrenia relapses repeatedly after returning to a home where relatives are highly critical, hostile and emotionally over-involved. The family factor most strongly linked to this pattern of relapse is:

(A) High expressed emotion in the family

(B) A low socio-economic status alone

(C) A large sibship size

(D) Good medication adherence

Q5. In a first episode of psychosis, the interval between the onset of frank psychotic symptoms and the start of effective treatment is an important prognostic marker. A longer duration of untreated psychosis (DUP) is associated with:

(A) A better long-term outcome

(B) A worse long-term outcome and poorer response to treatment

(C) No effect on outcome

(D) A guaranteed spontaneous recovery

Q6. Distinguishing two symptoms of the flow and control of thought: a sudden involuntary stopping of the train of thought with an empty pause versus the delusional belief that thoughts are being removed by an outside agency. These are, respectively:

(A) Thought block and thought withdrawal

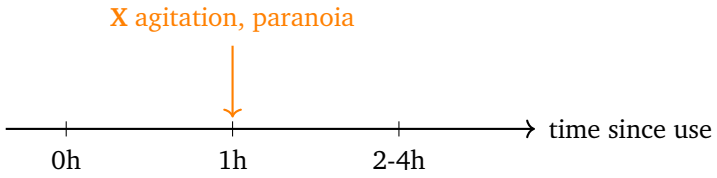
(B) Thought withdrawal and thought insertion

(C) Thought broadcasting and thought block

(D) Circumstantiality and thought insertion

Substance Use and Organic Disorders

Q7. The timeline below shows a young man brought in shortly after taking a stimulant (marked **X**): dilated pupils, tachycardia, hypertension, hyperthermia, agitation and paranoid ideas. This acute amphetamine or cocaine (or LSD) intoxication with psychosis is best managed by:



(A) Intravenous thiamine as the priority

(B) A high dose of a stimulant to counteract withdrawal

(C) Reassurance in a calm setting with benzodiazepines for agitation and supportive control of blood pressure and temperature

(D) Immediate long-term depot antipsychotic

Q8. An elderly hypertensive man with prior strokes shows cognitive decline that has worsened in abrupt steps rather than smoothly, with patchy deficits and focal neurological signs. The most likely diagnosis is:

(A) Alzheimer's disease

(B) Frontotemporal dementia

(C) Vascular dementia

(D) Dementia with Lewy bodies

Child, Neurodevelopmental and Personality Disorders

Q9. A 10-year-old boy who was previously cheerful becomes persistently irritable, complains repeatedly of headaches and stomach aches with no physical cause, refuses school and loses interest in play. The most likely explanation for this atypical presentation is:

(A) Childhood depression presenting as irritability and somatic complaints

(B) Simple truancy with no mental disorder

(C) Attention-deficit hyperactivity disorder

(D) Normal childhood behaviour needing no assessment

Q10. When assessing a toddler for possible developmental delay, the clinician compares the child's abilities against expected milestones across several domains. Which statement best captures how developmental delay is recognised?

(A) Delay is diagnosed only from a single language milestone

(B) Milestones are irrelevant once a child can walk

(C) Delay means the child is ahead of age expectations

(D) Failure to reach expected gross-motor, fine-motor, language and social milestones for the child's age signals developmental delay

Q11. An adult finds it very hard to make everyday decisions without excessive advice and reassurance, lets others take responsibility for major areas of life, feels helpless when alone and urgently seeks a new relationship when one ends. This describes which personality disorder?

(A) Narcissistic personality disorder

(B) Dependent personality disorder

(C) Antisocial personality disorder

(D) Schizoid personality disorder

Psychopharmacology and Therapeutics

Q12. A patient maintained on an atypical antipsychotic gains considerable weight over six months, with a rising fasting glucose and worsening lipid profile. Which drugs are most strongly associated with this metabolic syndrome picture?

(A) Haloperidol and fluphenazine

(B) Fluoxetine and sertraline

(C) Lithium and sodium valproate

(D) Olanzapine and clozapine

Q13. A 27-year-old woman with bipolar disorder is planning pregnancy and is currently on a mood stabiliser. Which principle should guide her drug management?

(A) Valproate is the safest choice and should be continued

(B) Valproate is highly teratogenic (neural-tube and other defects) and should be avoided in women of childbearing potential

(C) No mood stabiliser needs any monitoring in pregnancy

(D) Stopping all treatment abruptly is always the safest option

Emergency Psychiatry and Miscellaneous

Q14. A 40-year-old woman, two weeks after her husband's death, has waves of sadness and tearfulness, poor sleep, and brief experiences of hearing his voice, but keeps functioning and retains hope for the future. The most appropriate assessment is that this is:

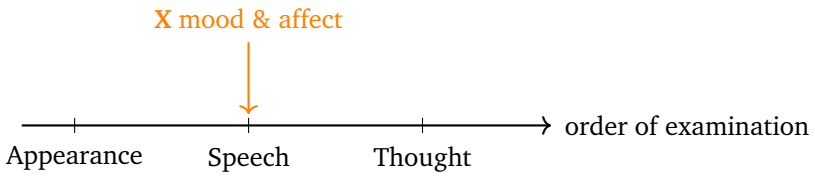
(A) A normal acute grief reaction needing support and monitoring

(B) A major depressive episode requiring immediate antidepressants

(C) A psychotic disorder requiring antipsychotics

(D) Malingering for sympathy

Q15. The schematic below outlines the ordered components a candidate should cover when structuring a mental state examination (the highlighted node, **X**, is one such component). Which sequence correctly reflects the standard structure of the MSE?



(A) Diagnosis, prescription and discharge only

(B) Blood tests, imaging and biopsy

(C) Family history and immunisation record only

(D) Appearance and behaviour, speech, mood and affect, thought, perception, cognition and insight

Detailed Solutions

Q1.

Solution

Concept – the kindling hypothesis of bipolar disorder: Kindling describes how repeated affective episodes progressively sensitise the brain.

Step 1 – read the schematic: Each successive episode is triggered by a smaller stress (**X**), so the threshold for a new episode keeps falling until episodes arise almost autonomously.

Step 2 – name the model: This progressive lowering of the episode threshold with each recurrence is the **kindling (sensitisation) hypothesis**, and it underlies the rationale for early and continued mood-stabiliser prophylaxis.

Why the other options are wrong:

- A, dopamine over-activity: is the classic hypothesis of schizophrenia, not of episode recurrence in bipolar disorder.
- B, monoamine depletion: is a hypothesis of depression, not of progressive kindling.
- D, dexamethasone suppression: is a neuro-endocrine test finding, not a model of episode recurrence.

Final Answer: The kindling (sensitisation) hypothesis $\Rightarrow$ C

Answer: (C) Go Back to Q1

Q2.

Solution

Concept – panic and health anxiety overlap: Panic attacks and illness anxiety commonly reinforce one another around somatic symptoms.

Step 1 – read the picture: Palpitations, chest tightness and breathlessness with a fear of a heart attack are typical **panic** symptoms; normal investigations yet a persistent conviction of serious heart disease between attacks is **health (illness) anxiety**.

Step 2 – link the two: The bodily sensations of panic are misinterpreted as evidence of grave disease, and that health-anxious belief in turn primes further panic, forming a self-reinforcing loop.

Why the other options are wrong:

- A, a missed cardiac illness: is excluded by repeatedly normal investigations.
- B, factitious disorder: needs deliberately produced or feigned signs, which are absent here.
- D, malingering: requires an external incentive, which is not present.

Final Answer: Panic driving an illness-anxiety preoccupation $\Rightarrow$ C

Answer: (C) Go Back to Q2

Q3.

Solution

Concept – anhedonia, apathy and abulia: These three terms describe distinct losses of pleasure, motivation and will.

Step 1 – define each term: Anhedonia is the loss of the capacity to experience pleasure; **apathy** is a loss of feeling, interest or motivation; **abulia** is a loss of will or the drive to initiate action.

Step 2 – apply to the stem: The loss of the capacity to feel pleasure is anhedonia, and the separate loss of drive and initiation is abulia, with apathy sitting between them as reduced motivation.

Why the other options are wrong:

- A: reverses the definitions of anhedonia and abulia.
- C: wrongly calls anhedonia an elevated mood.
- D: wrongly makes abulia excessive activity.

Final Answer: Anhedonia = loss of pleasure, apathy = loss of motivation, abulia = loss of will $\Rightarrow$ B

Answer: (B) Go Back to Q3

Q4.

Solution

Concept – expressed emotion and relapse: Expressed emotion is a measure of the emotional climate within a patient's family.

Step 1 – read the family climate: Relatives who are highly **critical, hostile and emotionally over-involved** constitute a high-expressed-emotion household.

Step 2 – link to relapse: High expressed emotion is a strong predictor of relapse in schizophrenia; family interventions that reduce it lower the relapse rate.

Why the other options are wrong:

- B, low socio-economic status alone: is a risk marker but not the specific relapse factor described.
- C, sibship size: is not an established relapse predictor.
- D, good adherence: protects against relapse rather than causing it.

Final Answer: High expressed emotion in the family $\Rightarrow$ A

Answer: (A) Go Back to Q4

Q5.

Solution

Concept – duration of untreated psychosis (DUP): DUP is the interval between the onset of psychosis and the start of effective treatment.

Step 1 – define the marker: A first episode of psychosis is often preceded by weeks or months of untreated symptoms; the length of that gap is the DUP.

Step 2 – state the prognosis: A **longer DUP** is associated with a **worse** long-term outcome and a poorer response to treatment, which is why early-intervention services aim to shorten it.

Why the other options are wrong:

- A, better outcome: is the opposite of the evidence.
- C, no effect: ignores the consistent link between DUP and prognosis.
- D, guaranteed recovery: overstates and is untrue.

Final Answer: A worse outcome and poorer treatment response $\Rightarrow$ B

Answer: (B) Go Back to Q5

Q6.

Solution

Concept – thought block versus thought withdrawal: Both disturb thinking, but one is a form disturbance and the other a delusion of control.

Step 1 – define thought block: Thought block is a sudden, involuntary cessation of the train of thought, leaving an empty pause, with no explanation offered by the patient.

Step 2 – define thought withdrawal: Thought withdrawal is the delusional be-

lief that one's thoughts are being removed by an external agency, and is a Schneiderian first-rank symptom.

Why the other options are wrong:

- B: pairs withdrawal with insertion, missing the described empty pause.
- C: introduces broadcasting, which is thoughts being shared, not stopping.
- D: circumstantiality is over-inclusive speech, not a sudden stop.

Final Answer: Thought block and thought withdrawal $\Rightarrow$ A

Answer: (A) Go Back to Q6

Q7.

Solution

Concept – acute stimulant (or LSD) intoxication: Amphetamine, cocaine and LSD produce a sympathomimetic and psychotic picture.

Step 1 – read the timeline: Soon after use (**X**), dilated pupils, tachycardia, hypertension, hyperthermia, agitation and paranoia point to acute stimulant intoxication with psychosis.

Step 2 – state the management: Manage in a **calm environment with reassurance**, use **benzodiazepines** for agitation, and control blood pressure and temperature supportively; a short course of antipsychotic may be added for persisting psychosis.

Why the other options are wrong:

- A, thiamine as priority: is the treatment for Wernicke encephalopathy, not stimulant toxicity.
- B, more stimulant: would worsen the intoxication.
- D, immediate depot antipsychotic: is inappropriate for an acute, likely self-limiting intoxication.

Final Answer: Calm setting, benzodiazepines and supportive care $\Rightarrow$ C

Answer: (C) Go Back to Q7

Q8.

Solution

Concept – vascular dementia: Vascular dementia results from cumulative cerebrovascular damage.

Step 1 – read the course: A **stepwise** decline (abrupt drops rather than a smooth slope), patchy deficits and **focal neurological signs** in a hypertensive man with prior strokes are characteristic.

Step 2 – the risk background: Vascular risk factors (hypertension, diabetes, smoking, atrial fibrillation) and imaging evidence of infarcts support the diagnosis.

Why the other options are wrong:

- A, Alzheimer's disease: shows a gradual, smooth decline with early memory loss and no focal signs.
- B, frontotemporal dementia: presents with early personality and behaviour change.
- D, Lewy body dementia: features fluctuating cognition, visual hallucinations and parkinsonism.

Final Answer: Vascular dementia $\Rightarrow$ C

Answer: (C) Go Back to Q8

Q9.

Solution

Concept – childhood depression: Depression in children often looks different from the adult presentation.

Step 1 – read the change: A previously cheerful child who becomes persistently **irritable**, has unexplained **somatic complaints** (headaches, stomach aches), refuses school and loses interest in play fits atypical childhood depression.

Step 2 – the teaching point: In children, irritability and physical complaints often replace the classic report of sadness, so depression must be actively considered.

Why the other options are wrong:

- B, simple truancy: ignores the pervasive mood and somatic change.
- C, ADHD: is inattention and hyperactivity, not this loss of interest and irritable low mood.
- D, normal behaviour: dismisses a clear functional decline.

Final Answer: Childhood depression with irritability and somatic complaints ⇒ A

Answer: (A) Go Back to Q9

Q10.

Solution

Concept – developmental milestones and delay: Development is tracked across gross-motor, fine-motor, language and social-personal domains.

Step 1 – state the principle: Developmental delay is recognised when a child **fails to reach the expected milestones for their age** across one or more of these domains.

Step 2 – apply it: Assessment compares the child against age norms in every domain rather than relying on a single skill, and significant delay in two or more domains suggests global developmental delay.

Why the other options are wrong:

- A, a single language milestone: is too narrow to define delay.
- B, milestones irrelevant after walking: is false; several domains are followed throughout.
- C, being ahead: describes advanced development, not delay.

Final Answer: Failure to reach expected milestones across domains ⇒ D

Answer: (D) Go Back to Q10

Q11.

Solution

Concept – dependent personality disorder: This disorder centres on an excessive need to be looked after.

Step 1 – match the pattern: Difficulty making everyday decisions without reassurance, letting others take responsibility, **clinging, submissive behaviour**, feeling helpless when alone and a **fear of separation** define dependent personality disorder.

Step 2 – the giveaway: Urgently seeking a replacement relationship when one ends reflects the fear of being left to care for oneself.

Why the other options are wrong:

- A, narcissistic: is grandiosity and a need for admiration.
- C, antisocial: is disregard for others' rights and rules.
- D, schizoid: is emotional detachment and a preference for solitude, the opposite of clinging.

Final Answer: Dependent personality disorder ⇒ B

Answer: (B) Go Back to Q11

Q12.

Solution

Concept – metabolic effects of atypical antipsychotics: Second-generation antipsychotics can cause a metabolic syndrome.

Step 1 – read the picture: Weight gain, rising fasting glucose and worsening lipids over months point to drug-induced metabolic syndrome.

Step 2 – name the worst offenders: Olanzapine and clozapine carry the highest metabolic burden and require regular monitoring of weight, glucose and lipids.

Why the other options are wrong:

- A, haloperidol and fluphenazine: are typical antipsychotics linked mainly to extrapyramidal side effects.
- B, fluoxetine and sertraline: are SSRIs, not the metabolic-heavy antipsychotics described.
- C, lithium and valproate: are mood stabilisers with different adverse-effect profiles.

Final Answer: Olanzapine and clozapine ⇒ D

Answer: (D) Go Back to Q12

Q13.

Solution

Concept – mood stabilisers in pregnancy: Choosing a mood stabiliser for a woman planning pregnancy is about balancing relapse risk against teratogenicity.

Step 1 – identify the key risk: Valproate is highly teratogenic, causing neural-tube defects and neuro-developmental harm, and should be **avoided** in women of childbearing potential.

Step 2 – the safer approach: Management is planned in advance with specialist

input, using the lowest effective risk option, folate supplementation and close monitoring rather than abrupt cessation.

Why the other options are wrong:

- A, continue valproate as safest: is directly wrong and dangerous.
- C, no monitoring needed: is unsafe; levels and the pregnancy are monitored.
- D, abrupt stopping of all treatment: risks a severe relapse and is not the safe default.

Final Answer: Valproate is teratogenic and must be avoided $\Rightarrow$ B

Answer: (B) Go Back to Q13

Q14.

Solution

Concept – normal acute grief: Grief after bereavement is a normal reaction, distinct from a depressive disorder.

Step 1 – read the features: Two weeks after a death, **waves of sadness and tearfulness**, disturbed sleep and brief experiences of hearing the deceased's voice, with preserved functioning and retained hope, describe a **normal acute grief reaction**.

Step 2 – the appropriate response: Provide support, validation and monitoring; watch for evolution into a depressive disorder if pervasive low mood, worthlessness or suicidal ideas develop.

Why the other options are wrong:

- B, major depression needing antidepressants: is premature when functioning and hope are preserved so soon after loss.
- C, a psychotic disorder: overreads the transient, mood-congruent perceptions of the deceased.
- D, malingering: is unfounded, as there is no external incentive.

Final Answer: A normal acute grief reaction needing support $\Rightarrow$ A

Answer: (A) Go Back to Q14

Q15.

Solution

Concept – structure of the mental state examination (MSE): The MSE is a systematic cross-section of the patient's mental state at interview.

Step 1 – read the schematic: The ordered components run through appearance, speech and thought, with mood and affect (**X**) among them.

Step 2 – give the full sequence: The standard MSE covers **appearance and behaviour, speech, mood and affect, thought, perception, cognition and insight**, and is documented after the psychiatric history.

Why the other options are wrong:

- A, diagnosis and discharge: are outcomes, not components of the MSE.
- B, blood tests and imaging: are investigations, not the MSE.
- C, family history and immunisation: belong to the history, not the mental state examination.

Final Answer: Appearance, speech, mood and affect, thought, perception, cognition, insight $\Rightarrow$ D

Answer: (D) Go Back to Q15

Answer Key

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