INI CET Psychiatry

Sample Paper – 9

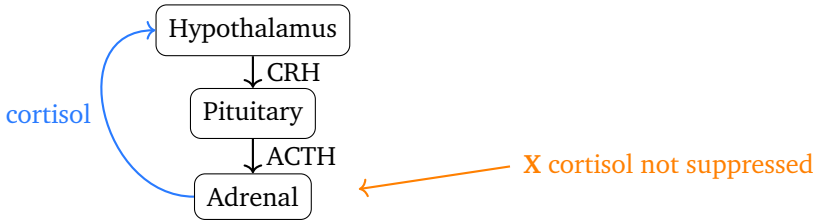
Duration: 14 Minutes **Maximum Marks: 15**

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 the hypothalamic-pituitary-adrenal (HPA) axis, where cortisol normally feeds back to switch off CRH and ACTH. In melancholic depression this axis is overactive, so a low overnight dose of dexamethasone fails to switch it off. The expected result (marked **X**) is:



(A) Complete suppression of cortisol after dexamethasone

(B) Undetectable ACTH with adrenal atrophy

(C) Non-suppression of cortisol after dexamethasone (a positive dexamethasone suppression test)

(D) A low morning cortisol with an exaggerated fall after dexamethasone

Q2. A patient with major depression has shown no meaningful improvement despite two separate antidepressants, each given at an adequate dose for an adequate duration. This situation is best defined and managed as:

(A) Failure of a single sub-therapeutic dose for one week; simply increase the dose

(B) Intolerance of one antidepressant; stop all drug treatment

(C) Failure after three days of any antidepressant; switch the drug at once

(D) Treatment-resistant depression (failure of two adequate trials); augment with lithium or an atypical antipsychotic

Q3. A student worries constantly about an exam next month, freezes in genuine terror when a dog actually lunges at him, and consistently avoids all lifts because of an out-of-proportion dread of them. Which statement correctly distinguishes fear, anxiety and a phobia?

(A) Fear and anxiety are identical, and a phobia is simply fear with no object

(B) Anxiety is always a response to a real and immediate danger in the present

(C) A phobia is a fleeting worry that never leads to avoidance

(D) Fear is a response to a real present threat, anxiety is apprehension about an anticipated threat, and a phobia is a persistent excessive fear of a specific object or situation that is avoided

Psychotic Disorders

Q4. A 72-year-old woman who lives alone develops well-organised persecutory delusions and partition delusions (a belief that people pass through

walls to harm her), with preserved affect, memory and cognition and no dementia. This is:

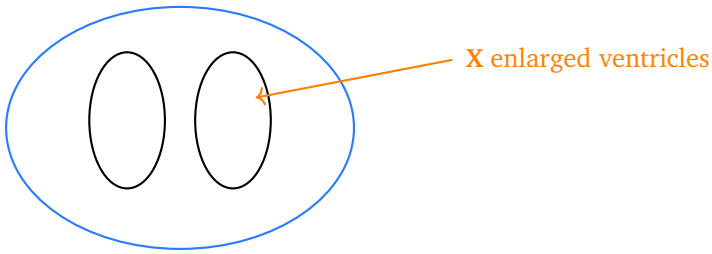
(A) Alzheimer's dementia

(B) Late-onset schizophrenia (late paraphrenia)

(C) Delirium

(D) Depressive pseudodementia

Q5. The brain schematic below highlights the most consistent structural and functional imaging finding in schizophrenia (marked **X**). This finding is:



reduced frontal activity (hypofrontality)

(A) Caudate atrophy with boxcar ventricles typical of Huntington's disease

(B) Hippocampal enlargement with frontal hyperactivity

(C) Cerebellar vermis hypertrophy

(D) Enlarged lateral ventricles with reduced frontal lobe activity (hypofrontality)

Q6. A man is intensely preoccupied that his body odour offends others and pursues this belief strongly, but he can just about accept he might be mistaken. Which statement correctly distinguishes an overvalued idea from a delusion?

(A) An overvalued idea is an understandable belief pursued strongly but not held with absolute unshakeable conviction, whereas a delusion is a fixed false belief held with absolute conviction and out of keeping with the person's background

(B) An overvalued idea is always bizarre and physically impossible

(C) A delusion can readily be argued away with evidence, whereas an overvalued idea cannot

(D) The two terms mean exactly the same thing

Substance Use and Organic Disorders

Q7. A man continues to drink despite documented liver damage. He now needs larger amounts for the same effect (tolerance), gets tremor and sweating when he stops (a withdrawal state), and drinking has taken priority over work and family (salience). Under ICD criteria this is:

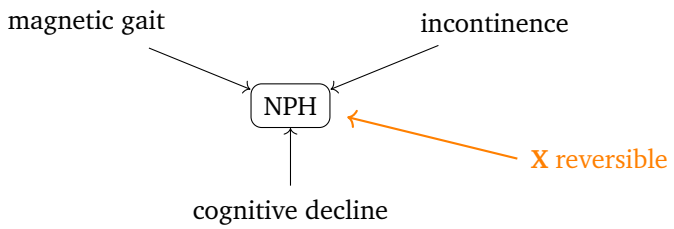
(A) Harmful use only

(B) Acute intoxication

(C) Dependence syndrome

(D) Hazardous use with no diagnosis

Q8. The schematic below shows a classic triad in an elderly man (marked **X**): a magnetic (shuffling) gait, urinary incontinence and cognitive decline, with dilated ventricles but a normal CSF opening pressure. This potentially reversible cause of dementia is:



(A) Normal-pressure hydrocephalus

(B) Alzheimer's disease

(C) Parkinson's disease

(D) Vascular dementia

Child, Neurodevelopmental and Personality Disorders

Q9. A 9-year-old repeatedly refuses to go to school, staying at home close to the parents. On school mornings he develops headaches and abdominal pain that quickly settle once he is allowed to stay home. The commonest underlying psychiatric association of this school refusal is:

(A) Separation anxiety disorder

(B) Conduct disorder

(C) Antisocial personality disorder

(D) Schizophrenia

Q10. When assessing an adult with intellectual disability, the severity of the disability and the person's real-world support needs are best judged by:

(A) The IQ score alone

(B) Chronological age alone

(C) Adaptive functioning across the conceptual, social and practical domains, considered together with the IQ

(D) The head circumference

Q11. A man has odd beliefs and magical thinking (he feels he can influence events by thought), unusual perceptual experiences, an eccentric appearance and marked social anxiety, but he has never had a frank psychotic episode. This pattern indicates:

(A) Schizoid personality disorder

(B) Paranoid personality disorder

(C) Schizotypal (personality) disorder

(D) Avoidant (anxious) personality disorder

Psychopharmacology and Therapeutics

Q12. Which statement about the pharmacology of anxiolytics and hypnotics is correct?

(A) The Z-drugs are 5-HT1A agonists with no action at the GABA system

(B) The Z-drugs (zolpidem, zopiclone) act at the benzodiazepine site of the GABA-A receptor, while buspirone is a 5-HT1A partial agonist that is non-sedating and does not cause dependence

(C) Buspirone produces immediate anxiolysis and is strongly dependence-forming

(D) Benzodiazepines block the GABA-A receptor and reduce chloride entry into the neuron

Q13. Which combination is a recognised dangerous interaction with a monoamine oxidase inhibitor (MAOI) antidepressant?

(A) Paracetamol, causing acute hepatic failure

(B) A tyramine-rich food (mature cheese) or a sympathomimetic, causing a hypertensive crisis

(C) Oral rehydration salts, causing hyponatraemia

(D) Vitamin C, causing an acute dystonia

Emergency Psychiatry and Miscellaneous

Q14. For a patient to be judged to have the capacity to consent to a proposed treatment, they must be able to:

(A) Understand and retain the relevant information, weigh it in the balance, and communicate a decision

(B) Simply agree with whatever the treating doctor recommends

(C) Have a normal IQ and carry no psychiatric diagnosis at all

(D) Be over 60 years of age

Q15. On day 5 after delivery, a woman becomes floridly psychotic with confusion, rapidly shifting delusions and thoughts of harming her baby. The correct management is:

(A) Reassure her and review in six weeks, as this is normal 'baby blues'

(B) Urgent psychiatric admission, ideally to a mother-and-baby unit, as this is postpartum psychosis (a psychiatric emergency)

(C) Start a mild anxiolytic at home with no follow-up

(D) Discharge her with vitamin supplements

Detailed Solutions

Q1.

Solution

Concept – the HPA axis in depression: Melancholic depression is associated with overactivity of the hypothalamic-pituitary-adrenal axis.

Step 1 – read the schematic: Normally cortisol from the adrenal feeds back to switch off CRH from the hypothalamus and ACTH from the pituitary.

Step 2 – apply the dexamethasone suppression test: Dexamethasone is a synthetic steroid that should mimic cortisol and switch the axis off. In depression the axis is overactive, so the cortisol **fails to suppress** (**X**): a positive dexamethasone suppression test.

Why the other options are wrong:

- A, complete suppression: is the *normal* healthy response, not the depressive finding.
- B, undetectable ACTH with adrenal atrophy: describes exogenous steroid excess, not depression.
- D, low cortisol with an exaggerated fall: is the opposite of the overactive axis seen here.

Final Answer: Non-suppression of cortisol after dexamethasone $\Rightarrow$ $\boxed{\text{C}}$

Answer: (C) Go Back to Q1

Q2.

Solution

Concept – treatment-resistant depression: Treatment resistance is defined by the failure of adequate treatment, not by a single poor trial.

Step 1 – apply the definition: Treatment-resistant depression is the failure to respond to **two** different antidepressants, each given at an **adequate dose** for an **adequate duration**.

Step 2 – the augmentation strategy: Recognised next steps include augmenting the antidepressant with **lithium** or an **atypical antipsychotic**, switching class, or considering ECT in severe cases.

Why the other options are wrong:

- A, a single sub-therapeutic dose for one week: is simply inadequate treat-

ment, not resistance.

- B, intolerance to one drug: is a side-effect problem; stopping all treatment is not indicated.
- C, failure after three days: is far too short to judge an antidepressant response.

Final Answer: Failure of two adequate trials; augment with lithium or an atypical antipsychotic $\Rightarrow$ D

Answer: (D) Go Back to Q2

Q3.

Solution

Concept – fear, anxiety and phobia: These three terms describe related but distinct emotional responses.

Step 1 – define each term: Fear is the response to a real, present threat (the lunging dog). **Anxiety** is apprehension about an anticipated or uncertain future threat (the exam next month).

Step 2 – add the phobia: A **phobia** is a persistent, excessive and out-of-proportion fear of a specific object or situation, leading to consistent **avoidance** (the lifts).

Why the other options are wrong:

- A, fear and anxiety identical: ignores the present-versus-anticipated distinction.
- B, anxiety as an immediate danger: that describes fear, not anxiety.
- C, a phobia with no avoidance: avoidance is a defining feature of a phobia.

Final Answer: Fear to a present threat, anxiety to an anticipated threat, phobia an avoided specific fear $\Rightarrow$ D

Answer: (D) Go Back to Q3

Q4.

Solution

Concept – late-onset schizophrenia (late paraphrenia): Schizophrenia can present for the first time in old age.

Step 1 – read the picture: Well-organised **persecutory** and **partition** delusions arising in an elderly woman who lives alone, with *preserved* affect, memory and

cognition, are the hallmark of late-onset schizophrenia (historically called late paraphrenia).

Step 2 – the key contrast: Crucially there is **no dementia**: cognition and memory are intact, which separates it from an organic cause.

Why the other options are wrong:

- A, Alzheimer's dementia: would show progressive memory and cognitive loss.
- C, delirium: is an acute, fluctuating confusional state with clouded consciousness.
- D, depressive pseudodementia: shows low mood with apparent cognitive slowing, not systematised delusions.

Final Answer: Late-onset schizophrenia (late paraphrenia) $\Rightarrow$ B

Answer: (B) Go Back to Q4

Q5.

Solution

Concept – the neuroanatomy of schizophrenia: Schizophrenia has consistent structural and functional brain correlates.

Step 1 – read the schematic: The most reproducible *structural* finding is **enlarged lateral ventricles** (**X**), reflecting a loss of surrounding brain tissue.

Step 2 – add the functional finding: Functionally there is **hypofrontality**, reduced activity of the prefrontal cortex, which correlates with the negative symptoms.

Why the other options are wrong:

- A, caudate atrophy and boxcar ventricles: describe Huntington's disease.
- B, hippocampal enlargement with frontal hyperactivity: is the reverse of the true findings (there is hippocampal *reduction* and *hypo*frontality).
- C, cerebellar vermis hypertrophy: is not a feature of schizophrenia.

Final Answer: Enlarged lateral ventricles with hypofrontality $\Rightarrow$ D

Answer: (D) Go Back to Q5

Q6.

Solution

Concept – overvalued idea versus delusion: Both are strongly held beliefs, but they differ in the degree of conviction and in how they fit the person's background.

Step 1 – define an overvalued idea: An **overvalued idea** is a comprehensible, understandable belief that comes to dominate a person's life and is pursued strongly, but it is *not* held with absolute, unshakeable conviction; some doubt remains (as with this man).

Step 2 – define a delusion: A **delusion** is a fixed, false belief held with **absolute conviction**, out of keeping with the person's social and cultural background, and not amenable to reason.

Why the other options are wrong:

- B, an overvalued idea always bizarre: it is by definition understandable, not bizarre.
- C, a delusion argued away with evidence: a delusion is precisely the belief that cannot be argued away.
- D, the terms synonymous: they are deliberately distinguished in psychopathology.

Final Answer: Overvalued idea = strong but not absolute conviction; delusion = fixed, absolute, out of keeping $\Rightarrow$ $\boxed{\text{A}}$

Answer: (A) Go Back to Q6

Q7.

Solution

Concept – dependence syndrome versus harmful use: ICD separates harmful use (damage from use) from the dependence syndrome (a cluster of physiological and behavioural features).

Step 1 – identify the dependence features: This man shows **tolerance** (needing more for the same effect), a **withdrawal state** (tremor and sweating on stopping) and **salience** (drinking taking priority over work and family).

Step 2 – apply the rule: Three or more such features together over the past year define the **dependence syndrome**, which is more than the physical damage of harmful use alone.

Why the other options are wrong:

- A, harmful use only: describes physical or mental damage *without* the dependence cluster.
- B, acute intoxication: is a transient state after a single dose, not a chronic pattern.
- D, hazardous use with no diagnosis: applies to risky use before any harm or dependence.

Final Answer: Dependence syndrome ⇒ C

Answer: (C) Go Back to Q7

Q8.

Solution

Concept – normal-pressure hydrocephalus (NPH): NPH is an important *reversible* cause of dementia.

Step 1 – read the triad: The classic triad (**X**) is a **magnetic (shuffling) gait**, **urinary incontinence** and **cognitive decline** ('wet, wobbly and wacky').

Step 2 – the confirming feature: There are dilated ventricles but a **normal** CSF opening pressure, and CSF shunting or a large-volume tap can reverse the symptoms.

Why the other options are wrong:

- B, Alzheimer's disease: gives a progressive amnestic dementia without this gait-and-incontinence triad.
- C, Parkinson's disease: gives tremor, rigidity and bradykinesia, not early incontinence with dementia.
- D, vascular dementia: gives a stepwise decline with focal signs, not this reversible triad.

Final Answer: Normal-pressure hydrocephalus ⇒ A

Answer: (A) Go Back to Q8

Q9.

Solution

Concept – school refusal: School refusal is a symptom, not a diagnosis, and it is driven by anxiety.

Step 1 – read the pattern: The child stays **close to the parents**, and the physical complaints appear on school mornings but settle once he is allowed to stay home.

Step 2 – name the association: This anxiety about leaving the attachment figures is the hallmark of **separation anxiety disorder**, the commonest psychiatric association of school refusal in younger children.

Why the other options are wrong:

- B, conduct disorder: underlies *truancy* (staying away from home for fun), not fearful refusal to leave the parents.
- C, antisocial personality disorder: is not diagnosed in a 9-year-old.
- D, schizophrenia: is not suggested by anxious clinging with somatic complaints.

Final Answer: Separation anxiety disorder $\Rightarrow \boxed{A}$

Answer: (A) Go Back to Q9

Q10.

Solution

Concept – assessing intellectual disability: Severity of intellectual disability is judged by real-world functioning, not by an IQ number alone.

Step 1 – state the modern principle: Severity is defined mainly by **adaptive functioning** across the **conceptual, social and practical** domains, considered together with the IQ, because it is adaptive skill that determines the level of support needed.

Step 2 – why this matters: Two people with the same IQ can need very different support depending on their day-to-day functioning.

Why the other options are wrong:

- A, IQ score alone: no longer sufficient; it ignores everyday functioning.
- B, chronological age alone: says nothing about the disability.
- D, head circumference: is not a measure of functioning or severity.

Final Answer: Adaptive functioning across conceptual, social and practical do-

mains with IQ $\Rightarrow$ C

Answer: (C) Go Back to Q10

Q11.

Solution

Concept – schizotypal disorder: Schizotypal disorder sits on the schizophrenia spectrum but without frank, sustained psychosis.

Step 1 – match the features: Odd beliefs and magical thinking, unusual perceptual experiences, an **eccentric** appearance and marked social anxiety, in someone who has never had a clear psychotic episode, define schizotypal disorder.

Step 2 – the boundary: The oddities are present, but they do not reach the threshold of the delusions and hallucinations of schizophrenia.

Why the other options are wrong:

- A, schizoid: is emotional detachment and a preference for solitude, without magical thinking.
- B, paranoid: is pervasive suspiciousness and mistrust, without the perceptual oddities.
- D, avoidant: is social inhibition from a fear of criticism, without odd beliefs.

Final Answer: Schizotypal (personality) disorder $\Rightarrow$ C

Answer: (C) Go Back to Q11

Q12.

Solution

Concept – anxiolytic and hypnotic pharmacology: The Z-drugs and buspirone act by different mechanisms.

Step 1 – the Z-drugs: Zolpidem and zopiclone act at the **benzodiazepine site of the GABA-A receptor**, enhancing chloride entry and so producing sedation.

Step 2 – buspirone: Buspirone is a **5-HT1A partial agonist**; it is non-sedating, has a delayed onset over a couple of weeks and does not cause dependence.

Why the other options are wrong:

- A, Z-drugs as 5-HT1A agonists: that is buspirone's mechanism, not the Z-drugs'.

- C, buspirone immediate and dependence-forming: buspirone is slow in onset and non-dependence-forming.
- D, benzodiazepines blocking GABA-A and reducing chloride: they *enhance* GABA and *increase* chloride entry.

Final Answer: Z-drugs at the GABA-A benzodiazepine site; buspirone a non-sedating 5-HT1A partial agonist ⇒ B

Answer: (B) Go Back to Q12

Q13.

Solution

Concept – MAOI cautions and interactions: Monoamine oxidase inhibitors block the breakdown of monoamines, so they interact dangerously with amine loads.

Step 1 – the tyramine ('cheese') reaction: Eating **tyramine-rich foods** (mature cheese, cured meats, some wines) or taking a **sympathomimetic** floods the body with amines the MAOI cannot break down, causing a **hypertensive crisis**.

Step 2 – the serotonin caution: MAOIs must also be kept well apart from SSRIs and other serotonergic drugs to avoid serotonin syndrome, which is why washout periods are used.

Why the other options are wrong:

- A, paracetamol: is not a specific MAOI interaction.
- C, oral rehydration salts: do not interact dangerously with MAOIs.
- D, vitamin C: does not cause a dystonia with MAOIs.

Final Answer: Tyramine-rich food or a sympathomimetic causing a hypertensive crisis ⇒ B

Answer: (B) Go Back to Q13

Q14.

Solution

Concept – capacity to consent: Capacity is decision-specific and rests on a defined set of abilities.

Step 1 – list the four abilities: The patient must be able to **understand** the relevant information, **retain** it long enough to use it, **weigh** it in the balance, and **communicate** a decision.

Step 2 – apply the principle: If all four are intact for that particular decision, the patient has capacity, whatever their diagnosis; capacity is presumed until shown otherwise.

Why the other options are wrong:

- B, agreeing with the doctor: a capacitous patient is fully entitled to *refuse* treatment.
- C, normal IQ and no diagnosis: a psychiatric or intellectual diagnosis does not automatically remove capacity.
- D, being over 60: age is irrelevant to capacity.

Final Answer: Understand, retain, weigh the information and communicate a choice ⇒ A

Answer: (A) Go Back to Q14

Q15.

Solution

Concept – postpartum psychosis: Postpartum psychosis is a true psychiatric emergency of the early puerperium.

Step 1 – recognise the picture: Florid psychosis with **confusion**, rapidly shifting **delusions** and thoughts of **harming the baby**, arising in the first days to two weeks postpartum, is postpartum psychosis, not the mild self-limiting 'baby blues'.

Step 2 – act on the risk: Because of the risk to both mother and baby, the correct step is **urgent psychiatric admission**, ideally to a **mother-and-baby unit** so mother and infant stay together while she is treated.

Why the other options are wrong:

- A, reassure as baby blues: dangerously underestimates a psychotic emergency with risk to the baby.
- C, a mild anxiolytic at home with no follow-up: fails to contain the risk.
- D, discharge with vitamins: ignores the psychiatric emergency entirely.

Final Answer: Urgent admission to a mother-and-baby unit (postpartum psychosis) ⇒ B

Answer: (B) Go Back to Q15

Answer Key

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