

**Running Head: TRAJECTORIES OF IRRITABILITY IN PRESCHOOLERS**

**Trajectories of Oppositional Defiant Disorder Irritability Symptoms in Preschool Children**

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Abstract

11 This study traces the developmental course of irritability symptoms in oppositional defiant disorder  
12 (ODD) from ages 3-5 and to study the psychopathological outcomes of the different trajectories at  
13 age 6. Method. A sample of 622 3-year-old preschoolers (311 were boys), followed up until age 6,  
14 was assessed yearly with a semi-structured diagnostic interview with parents and at age 6 with  
15 questionnaires answered by parents, teachers and children. Results. Growth-Mixture-Modeling  
16 yielded five trajectories of irritability levels for the whole sample (high-persistent 3.5%, decreasing  
17 3.8%, increasing 2.6%, low-persistent 44.1% and null 46.0%). Among the children who presented  
18 with ODD during preschool age, three trajectories of irritability symptoms resulted (high-persistent  
19 31.9%, decreasing 34.9% and increasing 33.2%). Null, low-persistent and decreasing irritability  
20 courses in the sample as a whole gave very similar discriminative capacity for children's  
21 psychopathological state at age 6, while the increasing and high-persistent categories involved  
22 poorer clinical outcomes than the null course. For ODD children, the high-persistent and increasing  
23 trajectories of irritability predicted disruptive behavior disorders, comorbidity, high level of  
24 functional impairment, internalizing and externalizing problems and low anger control at age 6.  
25 Conclusions. Irritability identifies a subset of ODD children at high risk of poorer longitudinal  
26 psychopathological and functional outcomes. It might be clinically relevant to identify this subset of  
27 ODD children with a high number of irritability symptoms throughout development with a view to  
28 preventing comorbid and future adverse longitudinal outcomes.

29 **KEYWORDS:** developmental trajectories; irritability; oppositional defiant; preschool.

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**Trajectories of Irritability Symptoms in Oppositional Defiant Disorder in Preschool Children**

11 Irritability is defined as “an excessive reactivity to negative emotional stimuli that has an  
12 affective component (anger) and a behavioral component (aggression)” (Leibenluft & Stoddard,  
13 2013, p. 1473), and is characterized by easy annoyance, low frustration, touchiness, and  
14 anger/temper outbursts. Irritability is moderately stable from school age to adulthood and heritable  
15 (heritability between 0.25 and 0.45 in childhood and adolescence), and has been described as a  
16 personality trait (Kuny et al., 2013; Stringaris, Zavos, Leibenluft, Maughan, & Eley, 2012).  
17 Irritability is a common symptom in different disorders, such as anxiety, depression and bipolar  
18 disorder, and specifically it is a core component of oppositional defiant disorder (ODD). Anger,  
19 hostility and irritability are all negative emotions relevant to disruptive behavior disorders. Such  
20 negative emotionality is correlated with self-regulation problems, which in turn, associates with  
21 behavioral difficulties (DeLisi & Vaughn, 2014). High negative emotionality has been proposed by  
22 temperament theorists as central in the etiology of antisocial behavior (DeLisi & Vaughn, 2014).

23 ODD is among the most prevalent disorders from preschool age (Ezpeleta, Osa, & Doménech,  
24 2014) to adulthood (Nock, Kazdin, Hiripi, & Kessler, 2007). ODD is accompanied by varied  
25 concurrent (attention deficit/hyperactivity disorder –ADHD) and successive (conduct disorder,  
26 anxiety, depression) comorbidity (Maughan, Rowe, Messer, Goodman, & Meltzer, 2004), and it is a  
27 strong predictor of depression in adulthood (Copeland, Shanahan, Costello, & Angold, 2009). In an  
28 attempt to explain this consistent comorbidity pattern, the underlying structure of ODD symptoms  
29 has been studied, and several dimensions of ODD have been identified in child-to-adolescent  
30 samples: irritable (including loses temper, angry and touchy); headstrong (argues, defies, annoys,  
31 blames), and hurtful (spiteful-vindictive) (Rowe, Costello, Angold, Copeland, & Maughan, 2010;  
32 Stringaris & Goodman, 2009b). Both cross-sectionally and longitudinally, the dimensions show  
33 distinct psychopathological associations: the irritable dimension is associated with emotional  
34 disorders, headstrong with attention deficit/hyperactivity

11 disorder (ADHD), and hurtful with conduct disorder (CD) and aggressive symptoms (Rowe et al.,  
 12 2010; Stringaris & Goodman, 2009a; Whelan, Stringaris, Maughan, & Barker, 2013). For  
 13 preschoolers, these dimensions (Ezpeleta, Granero, Osa, Penelo, & Doménech, 2012) as well as  
 14 Burke's model (Burke, Hipwell, & Loeber, 2010; Burke, Loeber, Lahey, & Rathouz, 2005) with  
 15 negative affect (touchy, angry, spiteful), oppositional behavior (temper, argues, defies) and  
 16 antagonistic behavior (annoys, blames) have been confirmed (Ezpeleta & Penelo, in press; Lavigne,  
 17 Bryant, Hopkins, & Gouze, 2014, in press). Based on these results, it has been suggested that the  
 18 association between ODD and depression or anxiety may be explained by the shared negative  
 19 affectivity and the irritability component.

20 For the definition of ODD, the recent DSM-5 (American Psychiatric Association, 2013)  
 21 classification separates the symptomatology following the above dimensions, but does not indicate  
 22 any specifier for cases in which ODD presents with strong or persistent irritability. On the  
 23 contrary, cases with marked, chronic irritability with severe recurrent temper outbursts are  
 24 classified under disruptive mood dysregulation disorder (DMDD) in the depressive section, a  
 25 diagnosis that cannot be made together with ODD. Copeland, Angold, Costello, and Egger (2013)  
 26 tested the proposed DSM-5 definition for DMDD in three samples from the general population  
 27 aged 2 to 17 and reported prevalence between 0.8 (ages 9-17) and 3.3% (ages 2-6) and a strong  
 28 overlap with ODD. According to these authors, the high comorbidity with ODD and the common  
 29 longitudinal association of both disorders with depressive disorders questions the classification of  
 30 DMDD as a mood disorder, given that both have mixed emotional and behavioral symptoms.  
 31 Recently, Dougherty et al. (2014) reported a prevalence of 8.2% for DMDD in a sample of 6-year-  
 32 old children and observed that the disorder was associated with depression and ODD. Therefore,  
 33 further study is needed regarding how chronic irritability presents through development.

34 Few studies have focused on person-centered analyses, which enable us to find groups of  
 35 children with similar responses in relation to irritability and to continue studying the outcomes for

11 the different groups of children. Using Latent Class Analysis in a large sample of 7-12-year-old  
12 Dutch twins to define subsets of ODD based on the 6 symptoms of the ODD scale in the Conners  
13 Parent Rating Scale, four classes emerged: no symptoms, defiant, irritability and high symptoms  
14 (Kuny et al., 2013). Children in the irritability category (10%) presented higher scores on anxious-  
15 depressed, withdrawn/depressed, and internalizing problems. Analogously, Althoff, Kuny-Slock,  
16 Verhulst, Hudziak, and van der Ende (2014) found similar categories using the DSM-oriented  
17 oppositional defiant problems scale of the CBCL in large samples from the general population in the  
18 U.S. and the Netherlands. The irritability category encompassed 22% of the sample; this class was  
19 concurrently associated with a lifetime diagnosis of anxiety disorders but not with a diagnosis of  
20 ODD, and predicted mood disorders 14 years later.

222 Few studies have centered on the outcomes of irritability specifically within children with  
223 ODD. One such study examined 7-12-year-old boys from a clinical sample that was over-  
224 representative of children with ADHD, ODD, and CD (Burke, 2012). The information provided by  
225 parents on ODD symptoms from the DISC interview from year 1 gave three categories of children:  
226 oppositional behavior (47.5%), irritability (36%), and low symptoms (16.4%). Children in the  
227 irritability category at year 1 showed more depressive and anxiety symptoms and higher neuroticism  
228 scores at follow-up at ages 17 and 18. In preschoolers from the general population, Lavigne, Gouze,  
229 Bryant, and Hopkins (2014) have reported that ODD irritable dimension scores at ages 4 and 5  
230 predicted subsequent depression but not anxiety. At these ages, however, the associations or  
231 predictions from irritability were not specific, given that other dimensions (such as headstrong or  
232 antagonistic behavior) were also associated with internalizing disorders (Ezpeleta et al., 2012;  
233 Lavigne et al., 2014). Therefore, more information is needed about the outcomes and specificities of  
234 irritability at younger ages. Using a variable-oriented approach, Dougherty et al. (2013) examined a  
235 large sample of preschoolers from the general population to determine whether chronic irritability at  
236 age 3 was related to negative psychopathological outcomes at age 6. Irritability, as defined through  
237 six symptoms in a diagnostic interview (irritable mood, feelings of anger, displays anger and  
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11 resentment, feelings of frustration, episodes of temper, and episodes of excessive temper), was  
12 associated concurrently and longitudinally with ODD, depressive disorders, and functional  
13 impairment, even when controlling for baseline symptomatology and excluding symptom overlap.  
14

15 Previous studies, mostly based on variable-oriented analyses, indicate that irritability marks a  
16 specific risk for subsequent internalizing disorders and suggest several subtypes of ODD. Most of the  
17 person-centered studies have been carried out in samples of children aged 7 and older which do not  
18 represent the general population (twins, clinical patients, or only boys), and have studied categories  
19 of ODD such as irritability, cross-sectionally, but none has longitudinally studied the trajectories of  
20 irritability in preschoolers in the context of ODD. The current conception of ODD is that it is a  
21 mixed behavior and emotion disorder that starts early in life and remains stable. Preschool age is  
22 developmentally important in relation to both anger (a high frequency of irritability symptoms;  
23 Egger & Angold, 2006) and emotion regulation, as most children are developing self-regulation  
24 skills during this period (Halligan et al., 2013). Therefore, it is imperative to know if irritability can  
25 identify subtypes of ODD at this early age. This information might be highly relevant for detection  
26 and might permit us to prevent subsequent internalizing psychopathology associated with ODD.  
27

28 Given this, we set three specific objectives in this study: 1) to trace the developmental trajectories of  
29 irritability symptoms as defined in DSM-IV ODD from ages 3 to 5 for a sample of preschool  
30 children representing the general population; 2) to trace the developmental trajectories of irritability  
31 symptoms among a subsample of children with ODD; and 3) to ascertain the outcomes of these  
32 trajectories at age 6. We expected to find several developmental trajectories of irritability both in the  
33 whole sample and among the children with ODD, with one trajectory being chronically irritable  
34 children (objectives 1 and 2). Among the children with ODD, we expected that the chronic trajectory  
35 would identify a subgroup of children with different outcomes in comparison to other irritability  
36 trajectories. With respect to the research carried out to date, we will add information regarding  
37 whether irritability specifies a distinct ODD group starting at preschool age using a person-centered  
38 longitudinal approach in a sample from the general population and with information from several  
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reporters (parents, teachers, and the children themselves).

## Method

### Participants

The sample derives from a longitudinal study on psychopathological risk factors starting at age 3 described in Ezpeleta et al. (2014). The initial sample consisted of 2,283 children randomly selected from early-childhood schools in Barcelona (Spain). A two-phase design was employed. In the first phase of sampling, 1,341 families (58.7%) agreed to participate (33.6% high socioeconomic status, 43.1% middle, and 23.3% low; 50.9% were boys). To ensure the participation of children with possible behavioral problems, the parent-rated SDQ (3-4 year-old version) conduct problems scale (Goodman, 2001) plus four ODD DSM-IV-TR symptoms were used to screen. Two groups were potentially considered: screen-positive (all children with SDQ scores  $\geq 4$ , percentile 90, or with a positive response for any of the 8 DSM-IV ODD symptoms), and screen-negative (a random group comprising 28% of children who did not reach the positive threshold). The number of refusals in this phase was  $n=135$  (10.6%), and these children did not differ in sex ( $\chi^2=0.05$ ,  $p=.815$ ) or type of school ( $\chi^2=0.04$ ,  $p=.850$ ) from those who did agree to participate. The only difference was in SES, with a higher participation ratio for high socioeconomic levels, 86.2% vs. 73.6%;  $\chi^2=14.09$ ,  $p=.007$ .

The final sample for the follow-up (second phase of sampling design) included 622 children first assessed at age 3. Demographic characteristics are shown in Table 1 (and Table S1 online). The screen-positive group comprised 417 children (49.4% boys) and the screen-negative group comprised 205 children (105, 51.2%, boys). At age 4, 603 children remained in the follow-up (97.4% of the initial screen positive group and 96.6% of the screen negative;  $\chi^2=0.28$ ,  $p=.598$ ) (303 boys), at age 5 there were 570 children (92.8% pertaining to the initial screen positive and 91.3% to the screen negative;  $\chi^2=0.45$ ,  $p=.502$ ) (288 boys), and at age 6 there were 511 children (83.4% for the initial screen positive group and 79.6% of the screen negative;  $\chi^2=1.36$ ,  $p=.244$ ) (256 boys). No differences in sex ( $\chi^2=1.57$ ;  $p=.21$ ), SES ( $\chi^2=8.63$ ;  $p=.071$ ) or type of school ( $\chi^2=0.39$ ;  $p=.53$ ) were found on comparing completers and drop-outs.



## Measures

11 The *Diagnostic Interview of Children and Adolescents for Parents of Preschool Children*  
 22 (DICA-PPC; Ezpeleta, Osa, Granero, Doménech, & Reich, 2011) is a semi-structured interview for  
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 44 (DICA-PPC; Ezpeleta, Osa, Granero, Doménech, & Reich, 2011) is a semi-structured interview for  
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 66 parents of children aged 3 to 7 that follows the DSM-IV-TR criteria (American Psychiatric  
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 88 Association, 2000). The interview was used to identify ODD diagnoses and the ODD dimensions  
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 110 described by Stringaris and Goodman (2009b): irritability symptoms (loses temper, touchy-annoyed  
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 112 and angry-resentful), headstrong (argues, defies, annoys, blames), and hurtful (spiteful-vindictive).  
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 114 The symptom count from the irritability dimension of ODD was used to yield the trajectories. The  
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 116 diagnoses analyzed as outcomes at age 6 were disruptive behavior disorders (ADHD, ODD, and  
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 118 CD), depressive disorders (major and minor depression) and anxiety disorders (separation and  
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 220 generalized anxiety, specific and social phobia), in addition to the number of CD-aggressive  
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 222 symptoms (bullying, fighting, weapon use, cruelty to people, cruelty to animals, stealing with  
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 224 confrontation, and forced sex) and CD-non-aggressive symptoms (fire-raising, vandalism, breaking  
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 226 and entering, lying, and stealing without confrontation). Comorbidity was defined as the presence of  
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 228 more than one disorder among those analyzed in the study. Use of services was recorded after  
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 330 assessment of the symptoms of each disorder. DICA-PPC diagnoses have shown acceptable test-  
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 332 retest agreement, ranging from kappa .76 for disruptive behavior disorders to .64 for anxiety  
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 334 disorders (Ezpeleta et al., 2011). Interviews were carried out by psychologists with master's degrees  
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 336 and psychology students supervised by two Ph.D. clinical child psychologists.

445 The *Child Behavior Checklist* (CBCL/6-18; Achenbach & Rescorla, 2001) measures a  
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 447 child's behavioral and emotional problems according to the parents' perception. Cronbach's alpha  
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 449 of the scales in the sample ranged from .46 for somatic complaints to .92 for total scale.

552 The *Strengths and Difficulties Questionnaire* (SDQ; Goodman, 2001) assesses children's  
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 554 mental health with 25 items on five scales: emotional symptoms, conduct problems, hyperactivity,  
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 556 peer relationship problems, and prosocial behavior. The items on the first four scales provide a total  
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 558 difficulties score. Two broader internalizing (emotional and peers) and externalizing (conduct and 8  
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hyperactivity) scales (Goodman, Lamping, & Ploubidis, 2010) were also analyzed. The questionnaire also has an impact supplement, which is useful for considering possible service use, and in which the informant judges whether the child has a problem and the degree of distress, social impairment, and burden it causes to others. This questionnaire was completed by teachers. Cronbach's alpha in the sample ranged from .60 for emotional symptoms to .82 for total scale.

The *Children's Global Assessment Scale* (CGAS; Shaffer et al., 1983) is a global measure of functional impairment rated by the interviewer based on information from the diagnostic interview. Scores above 70 indicate normal adaptation.

The *Anger Questionnaire* was created for this research project. It contains 40 items using a 3-point Likert-type scale (0: *not at all*; 1: *a little*; 2: *a lot*) related to the tendency to experience anger (Anger trait scale), to inadequately express anger (External expression scale), or to control anger appropriately (Control scale). The items included in each dimension were constructed by a committee of experts in developmental psychopathology based on a theoretical-clinical framework regarding anger at early ages. Children answered the questionnaire, which was read out by the researchers, at age 6. For the Anger trait scale, they were asked to indicate how often the situations happen to them (e.g., getting angry when asked to go to sleep, when another child takes his/her toys, or when it is difficult to do something, being in a bad mood when adults do not allow them to do something, getting angry easily, etc.). For the External expression and Control scales, the child was asked to say what s/he does when s/he gets angry (arguing, hitting, insulting, telling somebody off, trying to calm down, breathing deeply, etc.). Psychometric evidence of the reliability of the Anger-Questionnaire was obtained. A confirmatory factor analyses testing the internal structure of the questionnaire showed adequate fit for the 3-factor model, with low root mean square error of approximation index (RMSEA=0.064, 95% CI: 0.061 to 0.068), low standardized root mean squared residual (SRMR=0.069) and significant ( $p<.001$ ) and high standardized factor loadings (above 0.30) for all the items on their correspondent dimension (with the exception of three items with factor-scores between 0.19 and 0.22). Cronbach's alphas were adequate and equal to .79 for the Trait scale, .82 for the External expression scale, and .72 for the Control scale.

## Procedure

11 The project was approved by the ethics review committee of the authors' institution.  
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14 Families were recruited at the schools and gave their written consent. All families of children in  
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16 grade P3 (3-year-olds) in the participating schools were invited to answer the screening  
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18 questionnaire. Families who agreed were interviewed at the school for each assessment. The  
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20 interview team was specifically trained, and all interviewers were blind to the screening group (see  
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22 Ezpeleta et al., 2011). All interviews were audio-recorded and supervised. After the interview, the  
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24 interviewer completed the CGAS, the teachers were given the SDQ for completion before the end  
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26 of the academic year, and parents and children answered the questionnaires (at age 6). The data  
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28 were collected once a year between November 2009 and July 2013, with an average interval of  
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30 11.01 months between the first and second assessments (SD=1.15), 12.45 months (SD=1.19)  
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32 between the second and third assessments, and 10.81 months (SD=1.55) between the third and  
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34 fourth assessments. The average interval between the parent-family assessment and teacher's report  
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36 in the follow-ups ranged from 1.42 months (SD=1.80) for the first assessment to 2.84 months  
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38 (SD=1.89) for the fourth assessment.

## Statistical Analysis

39 The trajectories were obtained in MPlus7 using the sampling weight procedure to account  
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41 for the multi-sampling design (each child was weighted by the inverse proportion to the probability  
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43 of selection in the second phase of the sampling), through Growth-Mixture-Modeling (GMM) and  
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45 Robust-Maximum-Likelihood (MLR) (Enders & Bandalos, 2001; Muthén & Muthén, 2012). The  
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47 MLR constitutes a full-information method used for non-ignorable missing data modeling where  
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49 categorical outcomes are indicators of missingness and where missingness can be predicted by  
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51 continuous and categorical latent variables, and it gives robust standard errors and the T2\* chi-  
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53 square statistic test of Yuan and Bentler (2000) for all the parameters. Two GMMs were obtained  
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55 for the developmental course of the irritability symptoms during the preschool period (3 to 5 years  
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old): a) among the whole sample of  $n=622$  children (this model was adjusted for the presence of ODD during the follow-up) and b) among the subsample of  $n=103$  children who presented a diagnosis of ODD in the DICA-PPC at any of the three assessments of the preschool period -ages 3/4/5 years-old- (this model was adjusted for the number of headstrong symptoms). The selection of the number of trajectories for each model was based on: a) the lowest Bayesian information criterion (BIC); b) entropy  $>.80$ ; c) high on-diagonal average values (around  $.80$ ) in the matrix containing the probabilities of membership; d) the best clinical interpretability; and e) trajectory classes with enough sample sizes to allow statistical comparison (at least 5% of participants).

The other analyses were carried out with Complex Samples (due to the multi-stage sampling) in SPSS20, weighting each subject by the inverse proportion to the probability of selection in the second phase of the sampling. The capacity of trajectories to discriminate psychopathology and functioning at age 6 was measured with logistic regression (binary outcomes) and General Linear Models (GLM, quantitative criteria), adjusted for the presence of comorbidities different from those included in the models and the number of ODD-headstrong symptoms at baseline (age 3). Pairwise comparisons (odds ratio -OR- in logistics and mean differences -MD- in GLM) estimated differences between trajectories. Longitudinal discriminative models were obtained for the  $n=511$  children who remained in the follow-up at age 6 years-old. Due to the low sample size for some trajectories (with the consequent low statistical power), and since it is more relevant to measure and interpret the effect sizes than to make conclusions based on statistical significance tests, Cohen's- $d$  coefficients measured the effect size for each pairwise comparison (results did not include Bonferroni's corrections), considering moderate effect size as  $|d|>0.5$  and a large effect size as  $|d|>0.8$ .

## Results

### *Irritability trajectories in the whole sample*

GMM (adjusted for the presence of ODD during the follow-up) yielded five trajectories for

the number of irritability symptoms in the whole sample (Figure 1, left). Adequate fit was achieved (Table S2 online shows goodness-of-fit indexes, estimated/observed means, intercepts and slopes).

Trajectories 1 ( $N_1=237$ , 46.0%) and 2 ( $N_2=301$ , 44.1%) represented those children with no symptoms from ages 3 to 5 or with low persistent irritability symptoms. Trajectory 3 ( $N_3=35$ , 3.8%) represented high-decreasing irritability symptoms. Trajectory 4 ( $N_4=17$ , 2.61%) represented increasers, children who started with low mean symptoms at age 3 and showed an increase at age 5. And Trajectory 5 ( $N_5=32$ , 3.51%) represented those children with high-persistent symptoms. No statistical differences for trajectories emerged for children's sex ( $\chi^2=3.01$ ;  $p=.56$ ), socioeconomic status ( $\chi^2=11.1$ ;  $p=.20$ ) or ethnic group ( $\chi^2=6.16$ ;  $p=.19$ ).

The first rows of Table S3 online contain means for the number of ODD irritability, headstrong, and total symptoms for each trajectory, as well as the percentage of subjects who presented the hurtful symptom.

The first columns of Table 2 contains the distribution of the outcomes at age 6 (prevalences for binary responses and means for quantitative) for the five irritability trajectories obtained in the whole sample ( $N=511$  children who remained in the follow-up at age 6). The next columns contain the global predictive capacity of the trajectories ( $R^2$  coefficient) and the pair-wise comparisons selecting as the reference group the Trajectory 1 null irritability trajectory (that is, each trajectory was individually compared to the Trajectory 1 class). Low-persistent irritability course during preschool age (Trajectory 2) was very similar in its discriminative capacity for the outcomes at age 6 to that of null irritability course (Trajectory 1), and the only mean differences with moderate effect sizes (Cohen's- $d$  around 0.50) were for the number of ODD symptoms (irritability and total) and the level of functional impairment (poorer results for low-persistent children compared to null irritability children). The decreasing irritability course (Trajectory 3) also yielded similar outcomes at age 6 to those for null course (Trajectory 1), and relevant differences ( $|d|>.50$ ) were only for the number of ODD-irritability-symptoms, functional

impairment level, SDQ-internalizing scores and anger externalization and control levels (clinically poorer outcomes for children with the decreasing trajectory). Increasing and high-persistent irritability trajectories (Trajectories 4 and 5) achieved clearly the poorest outcomes at age 6, with moderate to high effect sizes for many differences compared to the null course trajectory (Trajectory 1). Specifically, increasing irritability course (Trajectory 4) was clinically worse than children in the null course for the presence of disruptive disorders (ODD), depression, comorbidity and use of services, as well as for the number of ODD-symptoms, functional impairment level, anxiety, aggressive behaviors, externalizing and total problems on the CBCL, and teachers' perceived higher levels of problems for relations with peers and for internalizing problems. Similarly, the high-persistent irritability course (Trajectory 5) also yielded a poorer psychopathological outcome than the null course in disruptive disorders (ODD), presence of comorbid disorders, impairment, number of ODD symptoms, the CBCL scales (except for somatic complaints and thought problems), anger externalization and control scores, and teachers' perceived higher levels of problems with peers, internalizing, global difficulties and interference with peers and at school.

#### *Irritability trajectories among children with ODD*

The GMM (adjusted for the number of headstrong symptoms during the follow-up) among the children with ODD at any time between ages 3 and 5 ( $N=103$ ) identified three irritability trajectories (Figure 1, right) with adequate fit (see goodness-of-fit in Table S2 online). Trajectory 1 ( $N_1=29$ , 34.9%) represented decreasing irritability symptomatology from ages 3 to 5 (children started with a moderate-high mean number of symptoms at age 3 and achieved considerably lower means at ages 4-5). Trajectory 2 ( $N_2=23$ , 33.2%) represented increasing irritability symptoms (children who started with a low mean number of symptoms at age 3 and had higher means at ages 4-5). Trajectory 3 ( $N_3=31$ , 31.9%) represented high-persistent (high mean number of symptoms at ages 3 to 5). The decline in the mean irritability scores between ages 3-5 for the high-persistent trajectory (means decreased from 1.85 to 1.70 and 1.54) was weak: the slope for this developmental

course was not statistically significant ( $b=-0.16$ ,  $t=-1.28$ ,  $p=0.20$ ). No statistical differences for trajectories emerged for children's sex ( $\chi^2=4.30$ ;  $p=.12$ ), socioeconomic status ( $\chi^2=8.41$ ;  $p=.078$ ), or ethnic group ( $\chi^2=0.38$ ;  $p=.83$ ).

The last rows of Table S3 online contain means for the number of ODD irritability, headstrong, and total symptoms for each trajectory. The means for the headstrong dimension and the ODD-total symptoms showed similar evolution to the ODD-irritability used to define the empirical trajectories, as well as the percentage of participants who presented the hurtful symptom.

#### *Outcomes of the irritability trajectories in children with ODD at age 6*

Table 3 summarizes outcomes at age 6 for the three irritability trajectories obtained for children with ODD during the preschool period ( $N=103$ ) and the comparisons carried out with the  $N=83$  children remaining at age 6. The first column on the left side shows the distribution of the outcomes (proportions or means), and the other columns contain the pairwise comparison for trajectories (OR in logistics and MD in GLM).

Considering significant differences and moderate-to-good effect sizes for pairwise comparisons, in comparison to both the increasing and high-persistent trajectories (2 and 3), Trajectory 1 (decreasing) showed lower prevalence for disruptive behavior disorders, ADHD (this comparison was relevant only for Trajectory 2=increasing vs Trajectory 1=decreasing), ODD, number of irritability symptoms, headstrong symptoms (relevant comparison for Trajectory 3=high-persistent vs Trajectory 1=decreasing), total ODD symptoms, comorbidity, use of services (relevant comparison for Trajectory 2=increasing vs Trajectory 1=decreasing) and functional impairment levels. Considering the CBCL mean scores, Trajectory 3 (high-persistent) yielded higher mean psychopathology levels than Trajectory 1 (increasing) on withdrawn/depressed, somatic complaints, rule-breaking, aggressive behavior, internalizing, externalizing and total scales. Trajectory 3 (high-persistent) also yielded lower self-reported control of anger than children in the decreasing trajectory (Trajectory 1). Teachers reported higher mean scores on the SDQ-conduct problems scale for children in the increasing (Trajectory 2) versus decreasing (Trajectory 1) groups.

High-persistent and increasing irritability trajectories only differed in the prevalence of depression and comorbidity (higher percentages for the increasing irritability class), and the mean scores in the CBCL withdrawn/depressed and rule-breaking scales (higher means for high-persistent irritability).

The last two columns of Table 3 show the comparison of Trajectories 2 and 3 clustered into the same group (increasing plus high-persistent irritability) with Trajectory 1 (decreasing irritability). Clustered Trajectories 2+3 showed the scores or proportions in the more dysfunctional direction for many outcomes: higher prevalences of DSM-IV disruptive behavior disorders, ODD and comorbidity, and higher mean scores for number of irritability and ODD-total symptoms, higher impairment and higher mean scores on the CBCL withdrawn/depressed, somatic complaints, rule-breaking, aggressive behavior, internalizing, externalizing and total scales.

### Discussion

This study identified several developmental trajectories of irritability symptoms included in DSM-IV ODD definition at preschool ages. A majority of the children in the sample representing the general population did not present irritability, or they presented it at very low levels, but 3.5% presented sustained irritability throughout this early developmental period. On the contrary, only a minority of preschoolers with ODD between ages 3 to 5 showed a decrease in their level of irritability (34.9%). Approximately 33% of children with ADHD showed increases in irritability with age, and about 32% of children with ODD showed persistent irritability. The persistence or increasing of irritability throughout the period studied was associated with poorer outcomes in both the general population sample and among the children with ODD. We did not find sex differences in irritability.

In the whole sample representing the general population, irritability was not a marked characteristic of most children (90%) from ages 3 to 5. However, 3.5% of the preschoolers from the general population did show persistent irritability. This value indicates sustained irritability problems for a significant proportion of preschoolers. Children in the high-persistent trajectory experience chronic states of arousal (lose temper, touchy-annoyed, angry-resentful) when most of their peers do not. Therefore, children in the early persistent and increasing trajectories of irritability



11 show early difficulties in managing irritability, which put them at risk for later socioemotional  
 12 development problems (Razza, Martin, & Brooks-Gunn, 2012). In our sample, as reported by  
 13 different informants in different contexts, these children continued to present with ODD, and had  
 14 more comorbidity (internalizing and externalizing), poorer functioning, and more difficulties with  
 15 peers. Developmentally, ODD is a risk factor for conduct disorder and other internalizing and  
 16 externalizing comorbidity, and conduct disorder is followed in a portion of cases by antisocial  
 17 personality disorder (Burke, Waldman, & Lahey, 2010; Maughan et al., 2004; Rowe, Maughan,  
 18 Pickles, Costello, & Angold, 2002). In this line, there is a body of literature that has reported  
 19 consistently that about 5% of the population from childhood to adulthood are involved in serious  
 20 antisocial behavior and show an elevated prevalence of violence, delinquency and substance use  
 21 (Vaughn et al., 2011; Vaughn, Salas-Wright, DeLisi, & Maynard, in press). The high persistent  
 22 trajectory in this study might be identifying children with these developmental risks, which  
 23 highlights the need for indicated prevention. Future research should test the differential efficacy of  
 24 preventive programs across the different developmental trajectories in order to improve their  
 25 efficacy.

26  
 27 Considering children with ODD, two groups were characterized by high irritability in their  
 28 development: the high-persistent and the increasing trajectory groups. Among the children with  
 29 ODD, approximately 32% presented with a high level of lasting irritability symptoms, while in 33%  
 30 the levels of irritability were increasing during the course of development. Children in the high-  
 31 persistent trajectory had high severity of ODD symptoms (rule-breaking) and withdrawn/depressed  
 32 behavior at age 6. For the children in these two trajectories emotional dysregulation worsened or  
 33 stayed at a dysfunctional level as they aged. Their increased difficulties in controlling irritability are  
 34 associated with highly negative outcomes, and they present the poorest outcomes in terms of  
 35 continuity and severity of ODD, internalizing and externalizing comorbidity, functional  
 36 impairment, and self-assessment of difficulties in anger control. The importance of the outcomes

with which these trajectories are associated, the effect sizes of the associations, and the cross-informant agreement on identifying the difficulties all support the empirical validity of these trajectories. High irritability (persistent or increasing) distinguishes a subtype of ODD children with marked difficulties in emotion regulation and poorer prognosis. Therefore, early identification of this subtype and early intervention must be a priority when an ODD diagnosis is given. Children in this subtype might benefit from a strengthening of the emotional components of existing intervention programs, such as emotional literacy, anger management, empathy or perspective-taking, social and communication skills, and interpersonal problem-solving (Webster-Stratton & Reid, 2004).

Previous studies have used variable-centered analyses to validate the structure of ODD symptoms (Burke, Hipwell, et al., 2010; Ezpeleta et al., 2012; Krieger et al., 2013; Rowe et al., 2010; Stringaris & Goodman, 2009b). Our contribution to previous studies is the validation of the ODD irritability subtype using a person-centered analysis. These results are in line with the ICD-11 (WHO, 2014) proposal to include a specifier to indicate whether the presentation of ODD includes chronic irritability and anger or not (Lochman et al., in press). Other studies have proposed another subtyping of ODD. In preschoolers, Willoughby, Waschbusch, Moore, and Propper (2011) reported that Callous-Unemotional traits distinguished a group of children with ODD who were less fearful, recovered more easily after an upset, and showed less negative reactivity, lower heart period reactivity, and higher levels of general arousal than those with ODD only. The different ODD subgroups identified in the literature indicate that ODD is a heterogeneous disorder and the distinct subgroups may require different treatment components.

Some limitations should be taken into account in interpreting the results of this study. Since we studied a very young sample of the general population, and psychopathology is not very frequent in such community samples, we found few cases of most disorders, particularly major depression and conduct disorders. Therefore, some associations could be affected by the low prevalence. As expected, few children from the general population presented ODD and, therefore, among the children with ODD, the distribution of the differently affected children into three

11 different trajectories might have reduced the statistical power of the analyses, and therefore effect  
 12 size measures were estimated and interpreted in this study. Related to sample sizes, it is usually  
 13 considered that statistical procedures underlying structural equation modeling and GMM require  
 14 large samples. However, it must be noted that there is not a general rule regarding how large a  
 15 sample is necessary for GMM and many recent publications state that identification of unobserved  
 16 groups with these procedures depends on many factors (Ram & Grimm, 2009) (extent of between-  
 17 group differences, homogeneity of the change process, group sizes or reliability of measurement),  
 18 and that small samples are sufficient under certain circumstances (Berlin, Parra, & Williams, 2014).  
 19 The theoretical framework of the present study, the goodness-of-fit of the trajectories and the proven  
 20 longitudinal discriminative capacity of the emerged latent-classes provide empirical validity to the  
 21 use of GMM in this data.

22 On the other hand, the strengths of the study are the use of a person-centered approach,  
 23 the inclusion of preschool children, and the use of information from several reporters (parent,  
 24 teacher, children) using several techniques (diagnostic interviews and questionnaires).

25 The identification of several irritability trajectories has important implications for early  
 26 diagnosis, treatment, and recommended preventive interventions. In the general population, by age  
 27 5 it is normative for children to present few symptoms of irritability, but we found that about 6%  
 28 of the children (persistent plus increasing) continued to show difficulties in emotional regulation  
 29 of irritability. These children had dysfunctional outcomes at age 6. These results highlight the  
 30 importance of observing and detecting levels of irritability early in development, as this is a risk  
 31 factor for psychopathological outcomes in children from the general population. Among the  
 32 children with ODD, high irritability (persistent and increasing) identifies a subtype of ODD with  
 33 the most severe outcomes, and these children should be identified and treated. Longitudinal  
 34 studies with longer follow-ups throughout childhood and adolescence are needed to further test the  
 35 predictive validity of this subtype.

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## **Conflict of interests**

The authors have no conflicts of interests.

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## References

- 11 Achenbach, T. M., & Rescorla, L. A. (2001). *Manual for the ASEBA school-age forms &*  
 12 *profiles*. Burlington, VT: University of Vermont, Research Center for Children,  
 13 *Youth & Families.*  
 14  
 15  
 16  
 17  
 18  
 19 Althoff, R. R., Kuny-Slock, A. V., Verhulst, F. C., Hudziak, J. J., & van der Ende, J. (2014).  
 110 Classes of oppositional-defiant behavior: Concurrent and predictive validity. *Journal*  
 111 *of Child Psychology & Psychiatry*, 55, 1162-1171. doi: doi:10.1111/jcpp.12233  
 112  
 113  
 114  
 115  
 116 American Psychiatric Association. (2000). *DSM-IV Diagnostic and statistical manual of*  
 117 *mental disorders* (4th Text Revised ed.). Washington, DC: American Psychiatric  
 118 *Press.*  
 119  
 120  
 121  
 122  
 123 American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental*  
 124 *disorders* (5th ed.). Arlington, VA: American Psychiatric Association.  
 125  
 126  
 127  
 128 Berlin, K. S., Parra, G. R., & Williams, N. A. (2014). An introduction to latent variable  
 129 mixture modeling (part 2): Longitudinal latent class growth analysis and growth  
 130 mixture models. *Journal of Pediatric Psychology*, 39, 188-203. doi:  
 131 10.1093/jpepsy/jst085  
 132  
 133  
 134  
 135  
 136  
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60  
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62  
63  
64  
65
- Burke, J. D., Loeber, R., Lahey, B. B., & Rathouz, P. J. (2005). Developmental transitions among affective and behavioral disorders in adolescent boys. *Journal of Child Psychology and Psychiatry*, *46*, 1200-1210.
- Burke, J. D., Waldman, I., & Lahey, B. B. (2010). Predictive validity of childhood oppositional defiant disorder and conduct disorder: Implications for the DSM-V. *Journal of Abnormal Psychology*, *119*, 739-751. doi: 10.1037/a0019708
- Copeland, W. E., Angold, A., Costello, E. J., & Egger, H. (2013). Prevalence, comorbidity, and correlates of DSM-5 proposed disruptive mood dysregulation disorder. *American Journal of Psychiatry*, *170*, 173-179. doi: 10.1176/appi.ajp.2012.12010132
- Copeland, W. E., Shanahan, L., Costello, E. J., & Angold, A. (2009). Childhood and adolescent psychiatric disorders as predictors of young adult disorders. *Archives of General Psychiatry*, *66*, 764-772.
- DeLisi, M., & Vaughn, M. G. (2014). Foundation for a temperament-based theory of antisocial behavior and criminal justice system involvement. *Journal of Criminal Justice*, *42*, 10-25. doi: 10.1016/j.jcrimjus.2013.11.0
- Dougherty, L. R., Smith, V. C., Bufferd, S. J., Carlson, G. A., Stringaris, A., Leibenluft, E., & Klein, D. N. (2014). DSM-5 disruptive mood dysregulation disorder: Correlates and predictors in young children. *Psychological Medicine*, *44*, 2339-2350. doi: 10.1017/s0033291713003115
- Dougherty, L. R., Smith, V. C., Bufferd, S. J., Stringaris, A., Leibenluft, E., Carlson, G. A., & Klein, D. N. (2013). Preschool irritability: Longitudinal associations with psychiatric disorders at age 6 and parental psychopathology. *Journal of the American Academy of Child Adolescent Psychiatry*, *52*, 1304-1313. doi: 10.1016/j.jaac.2013.09.007

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60  
61  
62  
63  
64  
65
- Egger, H. L., & Angold, A. (2006). Common emotional and behavioral disorders in preschool children: Presentation, nosology, and epidemiology. *Journal of Child Psychology and Psychiatry*, 47, 313-337.
- Enders, C. K., & Bandalos, D. L. (2001). The relative performance of full information maximum likelihood estimation for missing data in structural equation models. *Structural Equation Modeling*, 8, 430-457. doi: 10.1207/S15328007SEM0803\_5
- Ezpeleta, L., Granero, R., Osa, N. d. l., Penelo, E., & Doménech, J. M. (2012). Dimensions of oppositional defiant disorder in 3-year-old preschoolers. *Journal of Child Psychology and Psychiatry*, 53, 1128-1138. doi: 10.1111/j.1469-7610.2012.02545.x
- Ezpeleta, L., Osa, N. d. l., & Doménech, J. M. (2014). Prevalence of DSM-IV disorders, comorbidity and impairment in 3-year-old Spanish preschoolers. *Social Psychiatry and Psychiatric Epidemiology*, 49, 145-155. doi: 10.1007/s00127-013-0683-1
- Ezpeleta, L., Osa, N. d. l., Granero, R., Doménech, J. M., & Reich, W. (2011). The Diagnostic Interview for Children and Adolescents for Parents of Preschool Children. *Psychiatry Research*, 190, 137-144. doi: 10.1016/j.psychres.2011.04.034
- Ezpeleta, L., & Penelo, E. (in press). Measurement invariance of oppositional defiant disorder dimensions in 3-year-old preschoolers *European Journal of Psychological Assessment*. doi: 10.1027/1015-5759/a000205
- Goodman, R. (2001). Psychometric properties of the Strengths and Difficulties Questionnaire. *Journal of the American Academy of Child and Adolescent Psychiatry*, 40, 1337-1345. doi: 10.1097/00004583-200111000-00015
- Goodman, A., Lamping, D. L., & Ploubidis, G. B. (2010). When to use broader internalising and externalising subscales instead of the hypothesised five subscales on the strengths and difficulties questionnaire (SDQ): Data from British parents, teachers and children. *Journal of Abnormal Child Psychology*, 38, 1179-1191. doi: 10.1007/s10802-010-9434-x

- Halligan, S. L., Cooper, P. J., Fearon, P., Wheeler, S. L., Crosby, M., & Murray, L. (2013). The longitudinal development of emotion regulation capacities in children at risk for externalizing disorders. *Development and Psychopathology*, 25, 391-406. doi: 10.1017/s0954579412001137
- Krieger, F. V., Polanczyk, V. G., Robert, G., Rohde, L. A., Graeff-Martins, A. S., Salum, G., . . . Stringaris, A. (2013). Dimensions of oppositionality in a Brazilian community sample: Testing the DSM-5 proposal and etiological links. *Journal of the American Academy of Child and Adolescent Psychiatry*, 52, 389-400.e381.
- Kuny, A. V., Althoff, R. R., Copeland, W., Bartels, M., Van Beijsterveldt, C. E. M., Baer, J. C., & Hudziak, J. J. (2013). Separating the domains of oppositional behavior: Comparing latent models of the Conners' Oppositional Subscale. *Journal of the American Academy of Child and Adolescent Psychiatry*, 52, 172-183. doi: 10.1016/j.jaac.2012.10.005
- Lavigne, J. V., Bryant, F. B., Hopkins, J., & Gouze, K. R. (in press). Dimensions of oppositional defiant disorder in young children: Model comparisons, gender and longitudinal invariance. *Journal of Abnormal Child Psychology* doi: 10.1007/s10802-014-9919-0
- Lavigne, J. V., Gouze, K. R., Bryant, F. B., & Hopkins, J. (2014). Dimensions of oppositional defiant disorder in young children: Heterotypic continuity with anxiety and depression. *Journal of Abnormal Child Psychology*, 42, 937-951. doi: 10.1007/s10802-014-9853-1
- Leibenluft, E., & Stoddard, J. (2013). The developmental psychopathology of irritability. *Development and Psychopathology*, 25, 1473-1487. doi: 10.1017/S0954579413000722



- 11 Lochman, J. E., Evans, S. C., Burke, J. D., Roberts, M. C., Fite, P. J., Reed, G. M., . . .  
12  
13 Garralda, E. (in press). An empirically based alternative to DSM-5's disruptive mood  
14  
15 dysregulation disorder for ICD-11. *World Psychiatry*.  
16  
17  
18 Maughan, B., Rowe, R., Messer, J., Goodman, R., & Meltzer, H. (2004). Conduct disorder  
19  
20 and oppositional defiant disorder in a national sample: Developmental  
21  
22 epidemiology. *Journal of Child Psychology and Psychiatry*, 45, 609-621. doi:  
23  
24 10.1111/j.1469-7610.2004.00250.x  
25  
26  
27 Muthén, L. K., & Muthén, B. O. (2012). *Mplus User's Guide* (7th ed.). Los Angeles, CA:  
28  
29 Muthén & Muthén.  
30  
31  
32 Nock, M. K., Kazdin, A. E., Hiripi, E., & Kessler, R. C. (2007). Lifetime prevalence,  
33  
34 correlates, and persistence of oppositional defiant disorder: Results from the National  
35  
36 Comorbidity Survey Replication. *Journal of Child Psychology & Psychiatry*, 48, 703-  
37  
38 713. doi: 10.1111/j.1469-7610.2007.01733.x  
39  
40  
41 Ram, N., & Grimm, K. J. (2009). Growth mixture modeling: A method for identifying  
42  
43 differences in longitudinal change among unobserved groups. *International Journal*  
44  
45 *of Behavioral Development*, 33, 565-576.  
46  
47  
48 Razza, R. A., Martin, A., & Brooks-Gunn, J. (2012). Anger and children's socioemotional  
49  
50 development: Can parenting elicit a positive side to a negative emotion? *Journal of*  
51  
52 *Child and Family Studies*, 21, 845-856. doi: 10.1007/s10826-011-9545-1  
53  
54  
55 Rowe, R., Costello, E. J., Angold, A., Copeland, W. E., & Maughan, B. (2010).  
56  
57 Developmental pathways in oppositional defiant disorder and conduct disorder.  
58  
59 *Journal of Abnormal Psychology*, 119, 726-738. doi: 10.1037/a0020798  
60  
61  
62  
63  
64  
65

- 11  
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51  
52  
53  
54  
55  
56  
57  
58  
59  
60  
61  
62  
63  
64  
65
- Rowe, R., Maughan, B., Pickles, A., Costello, E. J., & Angold, A. (2002). The relationship between DSM-IV oppositional defiant disorder and conduct disorder: Findings from the Great Smoky Mountain Study. *Journal of Child Psychology and Psychiatry*, *43*, 365-373. doi: 10.1111/1469-7610.00027
- Shaffer, D., Gould, M. S., Brasic, J., Ambrosini, P., Fisher, P., Bird, H., & Aluwahlia, S. (1983). A Children's Global Assessment Scale (CGAS). *Archives of General Psychiatry*, *40*, 1228-1231. doi: 10.1001/archpsyc.1983.01790100074010
- Stringaris, A., & Goodman, R. (2009a). Longitudinal outcome of youth oppositionality: irritable, headstrong, and hurtful behaviors have distinctive predictions. *Journal of the American Academy of Child Adolescent Psychiatry*, *48*, 404-412. doi: 10.1097/CHI.0b013e3181984f30
- Stringaris, A., & Goodman, R. (2009b). Three dimensions of oppositionality in youth. *Journal of Child Psychology and Psychiatry*, *50*, 216-223. doi: 10.1111/j.1469-7610.2008.01989.x
- Stringaris, A., Zavos, H., Leibenluft, E., Maughan, B., & Eley, T. C. (2012). Adolescent irritability: Phenotypic associations and genetic links with depressed mood. *American Journal of Psychiatry*, *169*, 47-54. doi: 10.1176/appi.ajp.2011.10101549
- Vaughn, M. G., DeLisi, M., Gunter, T., Fu, Q., Beaver, K. M., Perron, B. E., & Howard, M. O. (2011). The severe 5%: A latent class analysis of the externalizing behavior spectrum in the United States. *Journal of Criminal Justice*, *39*, 75-80. doi: 10.1016/j.jcrimjus.2010.12.001
- Vaughn, M. G., Salas-Wright, C. P., DeLisi, M., & Maynard, B. R. (in press). Violence and externalizing behavior among youth in the United States: Is there a severe 5%? *Youth Violence and Juvenile Justice*. doi: 10.1177/1541204013478973

11 Webster-Stratton, C., & Reid, M. J. (2004). Strengthening social and emotional competence  
 12 in young children. The foundation for early school readiness and success - Incredible  
 13 years classroom social skills and problem-solving curriculum. *Infants and Young*  
 14 *Children, 17*, 96-113.  
 15  
 16

17 Whelan, Y. M., Stringaris, A., Maughan, B., & Barker, E. D. (2013). Developmental  
 18 continuity of oppositional defiant disorder subdimensions at ages 8, 10, and 13  
 19 years and their distinct psychiatric outcomes at age 16 years. *Journal of the*  
 20 *American Academy of Child Adolescent Psychiatry, 52*, 961-969. doi:  
 21 10.1016/j.jaac.2013.06.013  
 22  
 23

24 Willoughby, M. T., Waschbusch, D. A., Moore, G. A., & Propper, C. B. (2011). Using the  
 25 ASEBA to screen for callous unemotional traits in early childhood: Factor structure,  
 26 temporal stability, and utility. *Journal of Psychopathology and Behavioral*  
 27 *Assessment, 33*, 19-30. doi:10.1007/s10862-010-9195-4  
 28  
 29

30 World Health Organization. (2014). The International Classification of Diseases 11th  
 31 Revision is due by 2017. Retrieved December 28th, 2014, from  
 32 <http://www.who.int/classifications/icd/revision/en/>  
 33  
 34

35 Yuan, K. H., & Bentler, P. M. (2000). Three likelihood-based methods for mean and  
 36 covariance structure analysis with nonnormal missing data. In M. E. Sobel & M. P.  
 37 Becker (Eds.), *Sociological Methodology* (pp. 165-200). Washington, D.C.: ASA.  
 38  
 39  
 40  
 41  
 42  
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 45  
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Table 1

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22 *Demographic Characteristics of the Sample at baseline (n=622)*

33	Age (mean; SD)	3.8 (.33)
44	Sex (N;%)	Male 311 (50.0)
55	Race/ethnicity (N;%)	Non-Hispanic white 557 (89.5)
66		Hispanic-American 46 (7.4)
77		Other 19 (3.1)
88	Family socioeconomic status (N;%)	High 205 (33.0)
99		Mean-high 280 (45.0)
10		Low 137 (22.0)

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	Prevalences (% for binary outcomes) or means (for quantitative outcomes)					Global predic- tivity 4R <sup>2</sup>	Pairwise-comparison of each trajectory versus T1=null ~ = OR (binary variables) or MD (quantitative)							
	NullLow-pers.		Decreas.	Increas.	High-per.		T2vsT1		T3vsT1		T4vsT1		T5vsT1	
	T1(195)	T2(246)	T3(31)	T4(16)	T5(23)		~	d	~	d	~	d	~	d
Any difficulty; %	34.1	44.2	41.4	36.2	57.9	.016	1.54	0.21	1.37	0.15	1.10	0.04	2.71	<b>0.49+</b>
Impairm.-distress child; %	25.7	37.2	33.0	27.3	45.7	.020	1.73*	0.25	1.42	0.16	1.09	0.03	2.48	0.43
Interference with peers; %	18.0	31.9	21.7	31.2	41.3	.036	2.19*	0.32	1.30	0.09	2.09	0.31	3.31	<b>0.53+</b>
Interference in school; %	27.3	33.6	29.0	15.8	52.5	.019	1.35	0.14	1.09	0.04	0.51	0.28	2.97	<b>0.53+</b>
Burden in the school; %	17.0	20.7	21.2	19.2	18.7	.003	1.28	0.10	1.30	0.11	1.17	0.06	1.12	0.04

Note. <sup>1</sup>Proportions at 6 years old. <sup>2</sup>Means at 6 years old. In brackets, sample size. Depression includes major+minor depression. Anxiety includes separation, generalized, specific and social phobia. Trajectories: T1=null, T2=low persistent, T3= decreasing, T4: increasing, T5=high-persistent. OR: odds ratio. MD: mean difference. 4R<sup>2</sup>: change in R<sup>2</sup> on introducing the trajectories in comparison with the previous step including only the covariates presence of psychopathology and number of ODD-headstrong symptoms. |d|: Cohen's d coefficient measuring effect size for the pairwise comparisons.\*Significant result (.05 level). <sup>†</sup>Bold: moderate (|d|>0.5) to high (|d|>0.8) effect size. --- Not estimable due low sample size.

Table 3

*Outcomes of Irritability Trajectories at age 6 among Children with ODD (n=83)*

	% (for binary outcomes) or means (for quantitative)			Global predic- tivity 4R <sup>2</sup>	Pairwise-comparison (contrasts)						com pari son	Binary vsT1  d
	Decreas. T1(29)	Inreas. T2(23)	High-pers. T3(31)		~ = OR (binary variables) or MD (quantitative)							
					T2vsT1		T3vsT1		T3vsT2			
	~	d	~		d	~	d					
<i>DSM-IV disorders</i>												
Disruptive disorders	11.1	69.9	49.8	.325*	26.9*	<b>1.49<sup>1</sup></b>	10.2*	<b>0.93<sup>1</sup></b>	0.38	0.42	15.2*	<b>1.18<sup>1</sup></b>
ADHD	8.64	29.5	13.6	.095*	6.01*	<b>0.55<sup>1</sup></b>	1.63	0.16	0.27	0.39	2.96	0.36
ODD	9.06	51.5	41.2	.215*	11.8*	<b>1.04<sup>1</sup></b>	7.13*	<b>0.80<sup>1</sup></b>	0.60	0.21	8.92*	<b>0.91<sup>1</sup></b>
Conduc Disorder (CD)	0	0.44	2.85	.180*	2.50	0.09	---	0.24	---	0.19	---	0.23
Depression	2.69	11.4	0	.173*	---	0.35	---	0.24	---	<b>0.51<sup>1</sup></b>	2.14	0.15
Anxiety	14.9	5.13	11.2	.044	0.21	0.33	0.72	0.11	3.39	0.22	0.49	0.21
ODD: # irritability symptoms	0.33	1.70	1.29	.313*	1.36*	<b>1.65<sup>1</sup></b>	0.96*	<b>1.12<sup>1</sup></b>	-0.41	0.42	1.16*	<b>1.38<sup>1</sup></b>
ODD: # headstrong sympt.	0.86	1.20	1.64	.073*	0.34	0.30	0.79*	<b>0.64<sup>1</sup></b>	0.44	0.39	0.57	0.48
ODD: # total symptoms	1.27	3.07	3.20	.183*	1.81*	<b>1.02<sup>1</sup></b>	1.94*	<b>0.97<sup>1</sup></b>	0.13	0.06	1.88*	<b>1.00<sup>1</sup></b>
CD: # aggress. symptoms	0.13	0.09	0.03	.015	-0.04	0.11	-0.10	0.32	-0.06	0.21	-0.07	0.20
CD: # non-aggress. sympt.	0.10	0.07	0.21	.025	-0.03	0.10	0.11	0.26	0.14	0.35	0.04	0.11
Comorbidity (>1 disorder)	19.2	78.5	52.8	.302*	20.3*	<b>1.47<sup>1</sup></b>	5.90*	<b>0.75<sup>1</sup></b>	0.29	<b>0.56<sup>1</sup></b>	10.1*	<b>1.06<sup>1</sup></b>
Use of services; %	17.4	39.8	32.3	.061	3.31	<b>0.51<sup>1</sup></b>	2.27	0.35	0.69	0.16	2.72	0.43
Impairment (CGAS total)	75.6	63.8	66.7	.240*	-11.8*	<b>1.26<sup>1</sup></b>	-8.91*	<b>0.97<sup>1</sup></b>	2.89	0.30	-10.3*	<b>1.12<sup>1</sup></b>
<i>CBCL</i>												
Anxious-depressed	3.11	4.50	3.92	.029	1.39	0.48	0.81	0.22	-0.58	0.17	1.09	0.33
Withdrawn/depressed	0.69	1.13	2.04	.109*	0.44	0.37	1.35*	<b>0.72<sup>1</sup></b>	0.91*	<b>0.50<sup>1</sup></b>	0.90*	<b>0.57<sup>1</sup></b>
Somatic complaints	1.05	1.44	2.32	.074*	0.39	0.22	1.27*	<b>0.66<sup>1</sup></b>	0.88	0.44	0.84*	<b>0.50<sup>1</sup></b>
Social problems	2.25	2.79	3.31	.025	0.53	0.20	1.05	0.35	0.52	0.20	0.80	0.28
Thought problems	1.86	1.68	2.70	.037	-0.18	0.08	0.84	0.34	1.02	0.49	0.33	0.14
Attention problems	3.59	4.35	5.14	.032	0.76	0.22	1.55	0.43	0.79	0.23	1.16	0.33
Rule-breaking	1.33	1.85	2.88	.095*	0.53	0.27	1.55*	<b>0.69<sup>1</sup></b>	1.03*	<b>0.55<sup>1</sup></b>	1.05*	<b>0.50<sup>1</sup></b>
Aggressive behavior	5.85	8.36	10.3	.077*	2.51	0.43	4.50*	<b>0.59<sup>1</sup></b>	1.98	0.34	3.52*	<b>0.52<sup>1</sup></b>
Internalizing	4.85	6.98	8.25	.063	2.13	0.46	3.40*	<b>0.53<sup>1</sup></b>	1.27	0.23	2.78*	<b>0.50<sup>1</sup></b>
Externalizing	7.17	10.21	13.2	.087*	3.04	0.40	6.05*	<b>0.63<sup>1</sup></b>	3.01	0.41	4.57*	<b>0.53<sup>1</sup></b>
Total	23.0	30.4	37.9	.078*	7.37	0.37	14.9*	<b>0.61<sup>1</sup></b>	7.55	0.39	11.2*	<b>0.50<sup>1</sup></b>
<i>Anger questionnaire</i>												
Trait	10.4	9.52	10.9	.010	-0.89	0.16	0.53	0.09	1.42	0.24	-0.18	0.03
Externalization	6.48	6.17	6.21	.001	-0.31	0.06	-0.27	0.05	0.04	0.01	-0.29	0.06
Control	11.7	10.2	9.76	.066*	-1.53	0.46	-1.95*	<b>0.65<sup>1</sup></b>	-0.41	0.12	-1.74*	<b>0.55<sup>1</sup></b>
<i>SDQ-Teacher</i>												
Emotion	2.01	1.93	2.00	.000	-0.08	0.03	-0.01	0.00	0.07	0.04	-0.04	0.02
Conduct	1.13	2.22	1.19	.053	1.09	<b>0.50<sup>1</sup></b>	0.06	0.03	-1.03	0.46	0.58	0.27
Hyperactivity	2.91	4.07	4.21	.035	1.16	0.36	1.30	0.43	0.14	0.05	1.23	0.40
Peers	1.12	1.85	1.29	.036	0.73	0.44	0.17	0.11	-0.56	0.32	0.45	0.28
Prosocial	2.73	3.11	2.99	.004	0.38	0.14	0.26	0.10	-0.12	0.05	0.32	0.12
Internalizing	3.13	3.78	3.29	.007	0.65	0.18	0.16	0.05	-0.48	0.17	0.41	0.12
Externalizing	4.04	6.29	5.40	.036	2.24	0.45	1.36	0.28	-0.89	0.18	1.81	0.37
Total	7.18	10.07	8.70	.027	2.89	0.37	1.52	0.21	-1.37	0.20	2.22	0.30

	% (for binary outcomes) or means (for quantitative)			Global predic- tivity  4R <sup>2</sup>	Pairwise-comparison (contrasts) ~ = OR (binary variables) or MD (quantitative)						Binary comparison T2+T3 vs T1	
	Decreas.	Increases.	High-pers.		T2vsT1		T3vsT1		T3vsT2		~	d
	T1(29)	T2(23)	T3(31)		~	d	~	d	~	d		
Any difficulty; %	33.4	49.5	51.5	.036	2.09	0.33	2.27	0.37	1.09	0.04	2.18	0.35
Impairment-distress child; %	31.0	34.1	42.6	.014	1.16	0.07	1.68	0.24	1.46	0.18	1.40	0.15
Interference with peers; %	24.9	43.1	29.9	.037	2.43	0.39	1.30	0.11	0.53	0.28	1.78	0.26
Interference in school; %	19.7	35.7	41.5	.054	2.27	0.36	2.89	0.49	1.27	0.12	2.56	0.42
Burden in the school; %	10.8	27.5	22.0	.050	3.20	0.43	2.29	0.31	0.72	0.13	2.71	0.37

Note. <sup>1</sup>Proportions at 6 years old. <sup>2</sup>Means at 6 years old. In brackets, sample size. Depression includes major+minor depression. Anxiety includes separation, generalized, specific and social phobia. Trajectories: T1=decreasing, T2=increasing, T3=high-persistent. OR: odds ratio. MD: mean difference. 4R<sup>2</sup>: change in R<sup>2</sup> on introducing the trajectories in comparison with the previous step including only the covariate comorbidities other than ODD. |d|: Cohen's d coefficient measuring effect size for the pairwise comparisons.\*Significant result (.05 level). <sup>†</sup>Bold: moderate (|d|>0.5) to high (|d|>0.8) effect size. --- Not estimable due low sample size.



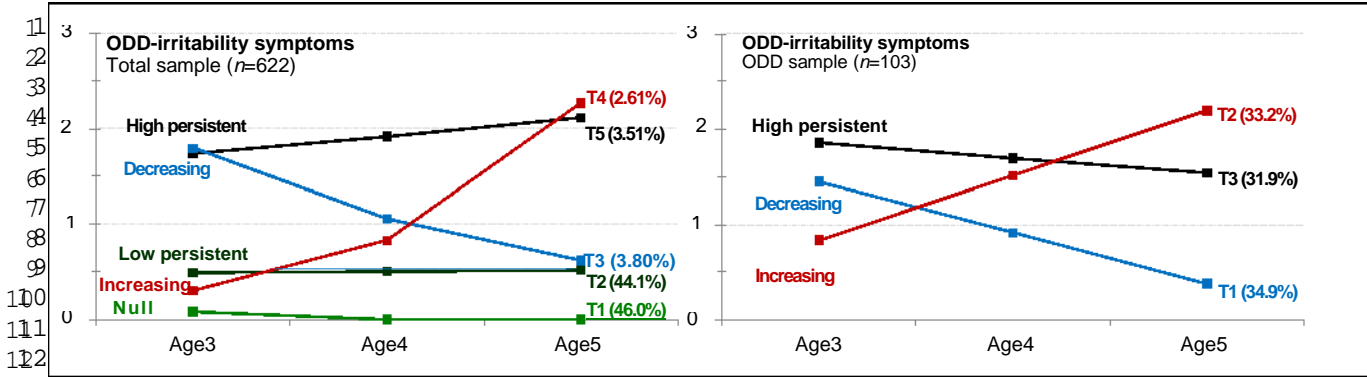


Figure 1. Developmental trajectories for the number of ODD-irritability symptoms, for total sample (n=622) and for ODD children sample (n=103 children who presented ODD during the preschool period).

## Trajectories of irritability in ODD preschoolers

1

Table S1.

*Demographic Characteristics of the Sample (N=622).*

<i>Child</i>					
Age (mean; SD)		3.8 (.33)	School (n; %)	Public	397 (63.8)
Sex (N; %)	Male	311 (50.0)		Semi-public	225 (36.2)
Race/ethnicity (N; %)	Non-Hispanic white	557 (89.5)	Living with... (n; %)	Both biological parents	585 (94.7)
	Hispanic- American	46 (7.4)		Adoptive parents	7 (1.1)
	Other	19 (3.1)		Reconstructed family	9 (1.5)
Family socioeconomic status (N; %)	High	205 (33.0)		One-parent family	30 (4.8)
	Mean-high	280 (45.0)	Born outside Spain (n; %)	Child	19 (3.1)
	Low	137 (22.0)		Mother	88 (14.2)
				Father	94 (15.6)
<i>Parents</i>		<i>Mother</i>	<i>Father</i>		
Age (mean; SD)		36.4 (4.7)	38.6 (5.8)		
Education (N; %)	College/university	340 (54.7)	279 (45.7)		
	High school/Incomplete college	178 (28.6)	197 (32.2)		
	Middle school/Incomplete high school	92 (14.8)	122 (20.0)		
	Elementary school or less	12 (1.9)	13 (2.1)		
Occupation (N; %)	Major/minor professional/administration	279 (45.1)	273 (45.7)		
	Technicians/Clerical/Skilled	200 (32.3)	237 (39.6)		
	Unskilled	140 (22.6)	88 (14.7)		
	Unemployed	112 (18.0)	46 (7.4)		

Note. Education unavailable for 11 fathers. SD: standard deviation.

Trajectories of irritability in ODD preschoolers 2

Table S2. Developmental trajectories for the number of ODD-irritability symptoms: GMM results.

	Trajectory	Post-prob.	Count-size	Prop. %	Model means			Observed means			Intercepts and slopes			
					Age3	Age4	Age5	Age3	Age4	Age5	Inter.	p	Slope	p
Sample: total; n=622	T1	.733	237	46.00	0.08	0	0	0	0	0	-2.52	<.001	-29.4	.999
BIC=3518.3	T2	.863	301	44.08	0.49	0.51	0.52	0.70	0.59	0.65	-0.71	<.001	0.026	.665
Entropy=.850	T3	.855	35	3.80	1.79	1.06	0.62	1.97	1.11	0.54	0.58	<.001	-0.529	.001
	T4	.930	17	2.61	0.30	0.83	2.27	0.56	0.19	2.55	-1.20	.007	1.01	<.001
	T5	.871	32	3.51	1.74	1.92	2.11	1.75	2.20	2.20	0.56	<.001	0.096	.074
Sample: ODD; n=103	T1	.962	35	34.86	1.45	0.91	0.38	1.47	0.59	0.47	1.45	<.001	-0.536	<.001
BIC=1822.6	T2	.956	29	33.22	0.84	1.51	2.19	0.84	1.07	2.36	0.84	<.001	0.679	<.001
Entropy=.870	T3	.936	39	31.92	1.85	1.70	1.54	1.90	1.53	1.62	1.85	<.001	-0.157	.201

Note. <sup>1</sup>On-diagonal posterior probabilities. <sup>2</sup>Weighted prevalence in each trajectory.

Table S3

*Means of ODD-dimension symptoms for the trajectories (percentage for hurtful symptom).*

Trajectory for ODD-irritability	ODD-Irritability (means)				ODD-Headstrong (means)				ODD-Hurtful symptom (%)				ODD-Total (means)			
	Age3	Age4	Age5	Age6	Age3	Age4	Age5	Age6	Age3	Age4	Age5	Age6	Age3	Age4	Age5	Age6
Sample: total; n=622																
T1-Null	0.00	0.00	0.00	0.20	0.18	0.16	0.19	0.21	0	0	0	1.03	0.18	0.16	0.19	0.41
T2-Low persistent	0.70	0.59	0.65	0.52	0.87	0.57	0.50	0.62	0	0	0.49	5.19	1.58	1.16	1.15	1.18
T3-Decreasing	1.97	1.11	0.54	0.55	2.31	1.53	1.03	0.76	0	0	5.72	15.2	4.28	2.63	1.63	1.46
T4-Increasing	0.56	0.19	2.55	1.58	1.19	0.97	2.41	1.17	0	0	3.74	4.20	1.75	1.15	5.00	2.79
T5-High persistent	1.75	2.20	2.20	1.89	1.64	2.50	2.06	1.59	0	0	17.7	44.4	3.39	4.70	4.44	3.93
Sample: ODD; n=103																
T1-Decreasing	1.47	0.59	0.47	0.35	2.58	1.09	0.20	0.89	0	0	2.5	8.2	4.04	1.69	0.70	1.32
T2-Increasing	0.84	1.07	2.36	1.66	0.70	1.28	2.07	1.15	0	0	4.9	17.1	1.54	2.36	4.48	2.97
T3-High persistent	1.90	1.53	1.62	1.31	2.68	2.63	2.51	1.67	0	0	18.0	27.3	4.59	4.15	4.31	3.25

Table S1.

*Demographic Characteristics of the Sample (N=622).*

<i>Child</i>				
Age (mean; SD)		3.8 (.33)	School (n; %)	Public 397 (63.8)
Sex (N; %)	Male	311 (50.0)		Semi-public 225 (36.2)
Race/ethnicity (N; %)	Non-Hispanic white	557 (89.5)	Living with... (n; %)	Both biological parents 585 (94.7)
	Hispanic- American	46 (7.4)		Adoptive parents 7 (1.1)
	Other	19 (3.1)		Reconstructed family 9 (1.5)
Family socioeconomic status (N; %)	High	205 (33.0)	One-parent family	30 (4.8)
	Mean-high	280 (45.0)	Born outside Spain (n; %)	Child 19 (3.1)
	Low	137 (22.0)		Mother 88 (14.2)
				Father 94 (15.6)
<i>Parents</i>		<i>Mother</i>	<i>Father</i>	
Age (mean; SD)		36.4 (4.7)	38.6 (5.8)	
Education (N; %)	College/university	340 (54.7)	279 (45.7)	
	High school/Incomplete college	178 (28.6)	197 (32.2)	
	Middle school/Incomplete high school	92 (14.8)	122 (20.0)	
	Elementary school or less	12 (1.9)	13 (2.1)	
Occupation (N; %)	Major/minor professional/administration	279 (45.1)	273 (45.7)	
	Technicians/Clerical/Skilled	200 (32.3)	237 (39.6)	
	Unskilled	140 (22.6)	88 (14.7)	
	Unemployed	112 (18.0)	46 (7.4)	

*Note.* Education unavailable for 11 fathers. SD: standard deviation.

Table S2. Developmental trajectories for the number of ODD-irritability symptoms: GMM results.

	Trajectory	<sup>1</sup> Post-prob.	Count-size	<sup>2</sup> Prop. %	Model means			Observed means			Intercepts and slopes			
					Age3	Age4	Age5	Age3	Age4	Age5	Inter.	$\rho$	Slope	$\rho$
Sample: total; $n=622$	T1	.733	237	46.00	0.08	0	0	0	0	0	-2.52	<.001	-29.4	.999
BIC=3518.3	T2	.863	301	44.08	0.49	0.51	0.52	0.70	0.59	0.65	-0.71	<.001	0.026	.665
Entropy=.850	T3	.855	35	3.80	1.79	1.06	0.62	1.97	1.11	0.54	0.58	<.001	-0.529	.001
	T4	.930	17	2.61	0.30	0.83	2.27	0.56	0.19	2.55	-1.20	.007	1.01	<.001
	T5	.871	32	3.51	1.74	1.92	2.11	1.75	2.20	2.20	0.56	<.001	0.096	.074
Sample: ODD; $n=103$	T1	.962	35	34.86	1.45	0.91	0.38	1.47	0.59	0.47	1.45	<.001	-0.536	<.001
BIC=1822.6	T2	.956	29	33.22	0.84	1.51	2.19	0.84	1.07	2.36	0.84	<.001	0.679	<.001
Entropy=.870	T3	.936	39	31.92	1.85	1.70	1.54	1.90	1.53	1.62	1.85	<.001	-0.157	.201

Note. <sup>1</sup>On-diagonal posterior probabilities. <sup>2</sup>Weighted prevalence in each trajectory.

Table S3

*Means of ODD-dimension symptoms for the trajectories (percentage for hurtful symptom).*

Trajectory for ODD-irritability	ODD-Irritability (means)				ODD-Headstrong (means)				ODD-Hurtful symptom (%)				ODD-Total (means)			
	Age3	Age4	Age5	Age6	Age3	Age4	Age5	Age6	Age3	Age4	Age5	Age6	Age3	Age4	Age5	Age6
Sample: total; <i>n</i> =622																
T1-Null	0.00	0.00	0.00	0.20	0.18	0.16	0.19	0.21	0	0	0	1.03	0.18	0.16	0.19	0.41
T2-Low persistent	0.70	0.59	0.65	0.52	0.87	0.57	0.50	0.62	0	0	0.49	5.19	1.58	1.16	1.15	1.18
T3-Decreasing	1.97	1.11	0.54	0.55	2.31	1.53	1.03	0.76	0	0	5.72	15.2	4.28	2.63	1.63	1.46
T4-Increasing	0.56	0.19	2.55	1.58	1.19	0.97	2.41	1.17	0	0	3.74	4.20	1.75	1.15	5.00	2.79
T5-High persistent	1.75	2.20	2.20	1.89	1.64	2.50	2.06	1.59	0	0	17.7	44.4	3.39	4.70	4.44	3.93
Sample: ODD; <i>n</i> =103																
T1-Decreasing	1.47	0.59	0.47	0.35	2.58	1.09	0.20	0.89	0	0	2.5	8.2	4.04	1.69	0.70	1.32
T2-Increasing	0.84	1.07	2.36	1.66	0.70	1.28	2.07	1.15	0	0	4.9	17.1	1.54	2.36	4.48	2.97
T3-High persistent	1.90	1.53	1.62	1.31	2.68	2.63	2.51	1.67	0	0	18.0	27.3	4.59	4.15	4.31	3.25