Appendix S1.

The English and German anonymous questionnaires were created with the following components:

Demographic data collected included age, gender, employment, education, marital status, and country of residence (U.S. or GS country).

Diagnosis and disease severity covered participants' diagnosis (AA, AGA), disease duration, family history and disease's impact on mood. Individuals with AA used clinical cartoons to self-assess disease severity across four stages[1], AGA individuals used adapted pictures from the simplified Hamilton Norwood (4 stages) and Ludwig scale (3 stages) for men and women, respectively[2].

Disease-related QoL was evaluated by the 48-item Hairdex in functioning, emotions, symptoms, self-confidence, and stigmatization on a 5-point Likert scale with higher values indicating lower QoL[3,4]. The U.S. questionnaire included the Dermatology Life Quality Index (DLQI) and the 20-Item Short Form Survey (SF-20) to address the construct validity of the English Hairdex, which has not yet been psychometrically tested [5,6].

Stigmatization was evaluated using the 21-item Perceived Stigmatization Questionnaire (PSQ), categorized into absence of friendly, rigid/confused, and hostile behaviour and PSQ total scores. Stigma increased with increasing mean scores [7,8].

Social support was measured from 1 to 5 (high support) using the 20-item Contextual Illness Support Scale (CISS) for the U.S. and the revised 20-item Illness-specific social support scale (ISSS; original 26-item) for the GS sample The Contextual Illness Support Scale (CISS) is a disease-specific social support questionnaire that also captures stressful interactions. The questions capture positive as well as negative aspects of social support specific to the situation of an illness.

Resilience was measured with the 6-item Brief Resilience Scale (BRS) evaluating an individual's ability to recover from stress despite adversity. Higher mean sum scores suggested resilience [11,12]. *Happiness* according to Ed Diener was measured by three components: Satisfaction with life (SWL) [13], Positive (PA) and Negative Affect (NA) measured by the Scale of positive and negative experience (SPANE) [14].

Mental health was assessed using the WHO-5 measuring well-being with lower scores suggesting depression [15,16] and the Generalized Anxiety Disorder 7 (GAD-7) [17,18].

References for validated German questionnaires and tools

1. Altmeyer P. A. Therapielexikon Dermatologie und Allergologie: Therapie kompakt von A bis Z. Berlin, Heidelberg: Springer Berlin Heidelberg; 2005: p. 41.
2. Moll I. Dermatologie. Stuttgart: Thieme; 2016.
3. Fischer TW, Schmidt S, Strauss B, Elsner P. [Hairdex: a tool for evaluation of disease-specific quality of life in patients with hair diseases]. Hautarzt 2001; 52: 219-227.
4. Freites-Martinez A, Shapiro J, Chan D, Fornier M, Modi S, Gajria D, et al. Endocrine Therapy-Induced Alopecia in Patients With Breast Cancer. JAMA Dermatol 2018; 154: 670-675.
5. Stewart AL, Hays RD, Ware JE, Jr. The MOS short-form general health survey. Reliability and validity in a patient population. Med Care 1988; 26: 724-735.
6. Finlay AY, Khan GK. Dermatology Life Quality Index (DLQI)--a simple practical measure for routine clinical use. Clin Exp Dermatol 1994; 19: 210-216.
7. Lawrence JW, Fauerbach JA, Heinberg LJ, Doctor M, Thombs BD. The reliability and validity of the Perceived Stigmatization Questionnaire (PSQ) and the Social Comfort Questionnaire (SCQ) among an adult burn survivor sample. Psychol Assess 2006; 18: 106-111.
8. Müller A, Smits D, Claes L, Jasper S, Berg L, Ipaktchi R, et al. Validation of the German version of the Perceived Stigmatization Questionnaire/Social Comfort Questionnaire in adult burn survivors. Burns 2016; 42: 790-796.
9. Revenson TA, Schiaffino KM, Majerovitz SD, Gibofsky A. Social support as a double-edged sword: the relation of positive and problematic support to depression among rheumatoid arthritis patients. Soc Sci Med 1991; 33: 807-813.
10. Ramm GC, Hasenbring M. Die deutsche Adaptation der Illness-specific Social Support Scale und ihre teststatistische Überprüfung beim Einsatz an Patienten vor und nach Knochenmarktransplantation. Z Med Psychol 2003; 12: 29-38.
11. Smith BW, Dalen J, Wiggins K, Tooley E, Christopher P, Bernard J. The brief resilience scale: Assessing the ability to bounce back. International Journal of Behavioral Medicine 2008; 15: 194-200.
12. Chmitorz A, Wenzel M, Stieglitz RD, Kunzler A, Bagusat C, Helmreich I, et al. Population-based validation of a German version of the Brief Resilience Scale. PLoS One 2018; 13: e0192761.
13. Diener E, Emmons RA, Larsen RJ, Griffin S. The Satisfaction With Life Scale. J Pers Assess 1985; 49: 71-75.
14. Diener E, Wirtz D, Tov W, Kim-Prieto C, Choi D-w, Oishi S, Biswas-Diener R. New Well-being Measures: Short Scales to Assess Flourishing and Positive and Negative Feelings. Social Indicators Research 2010; 97: 143-156.

15. Topp CW, Østergaard SD, Søndergaard S, Bech P. The WHO-5 Well-Being Index: a systematic review of the literature. Psychother Psychosom 2015; 84: 167-176.
16. Brähler E, Mühlan, H., Albani, C., & Schmidt, S. (2007). Teststatistische prüfung und normierung der deutschen versionen des EUROHIS-QOL Lebensqualität-index und des WHO-5 Wohlbefindens-index [Testing and standardization of the German version of the EUROHIS-QOL and WHO-5 quality-of life-indices]. Diagnostica, 53(2), 83–96.
17. Spitzer RL KK, Williams JBW, Löwe B. A Brief Measure for Assessing, Disorder GA, Med. TG-AI, 2006;166(10):1092–1097.
18. Löwe B MIS, Brähler E, Kroenke K, Albani C, Decker O. Validierung und, 2007 NekSzGAG-iersSddAlPPM.

Appendix S2.

The sociodemographic data, the Hairdex, Dermatological Life Quality Index (DLQI), Perceived Stigmatization Questionnaire (PSQ), and social support analysis were restricted to complete cases only. Across the variables of the Brief Resilience Scale (BRS), Satisfaction with Life Scale (SWL), Scale of Positive and Negative Experience (SPANE), Generalized Anxiety Disorder 7 (GAD-7), WHO-5 percentage of missing values varied between 0 and 17%. No association in missing cases was found with gender, age, severity, PSQ score. We looked at the values using multiple imputation for incomplete variables leading to 20 imputed datasets obtaining similar results. When restricting the analysis to complete cases only, similiar results were obtained without lower p-values as a favorable impact. Due to efficiency, it was decided to only use complete data cases in the end. Of those 549 German-speaking participants, 8 cases were excluded because they stated to never experienced hair loss, and 16 were excluded because they reported being diagnosed with other forms of alopecia. Of the U.S. sample 24 cases were excluded because of neither being diagnosed with AA nor AGA.

Appendix S3.
The sociodemographic variables marital status, educational level and employment were categorized for the regression. Marital status was categorized relationship (married, domestic relationship) and single (single, divorced, widowed). Educational level was categorized into High (Postgraduate (Doctorate), Master's, Bachelor's, Community college), Moderate (High school, Middle school, Associate's degree, Professional degree) and Low (No degree). Employment was categorized into employed, self-employed, student, unemployed (including retired persons.)

Appendix S4.

The assumptions of linear regression were tested using the Durbin-Watson test for autocorrelation and tolerance levels as a measure of multicollinearity. Plots of residual errors were used to check linearity, normality and heteroscedasticity.

Correlations (STable 1, 2) between individual variables were also taken into account for the analysis. For instance, Resilience (BRS), SWL and WHO-5 and Hairdex subscale stigma correlated, showing not being independent and thus not included for reasons of multicollinearity.