Dear Reviewer 4,

Thank you so much for your time in reviewing this manuscript and for your thoughtful comments. I have copied your comments below, with my responses in red.

More clearly identify the qualitative research design (e.g., phenomenology) and approach in the study. For example, the authors state they used purposive sampling, but then describe an approach that sounds like consecutive sampling Ii.e. quantitative methodology) in lines 89-92. Also, terminology of superordinate and subordinate themes aligns with interpretive phenomenology approach, yet Braun & Clarke (2006) is referenced for thematic analysis.

Thank you very much for this feedback, we have reworded the design description as highlighted below:

This study employed phenomenological qualitative methodology to gain an understanding of the lived experiences of burn patients. Thematic analysis was used to identify patterns of meaning in the data [20]. Purposive sampling was used to recruit participants who had previously experienced a burn injury to limit sample heterogeneity. Participants were required to be 18+ years old, not receiving psychological support, and under the care of the Burns team. Patients attending outpatient clinics in the service were screened for eligibility by AC and LM and were contacted via phone to participate.

Linkages with the underlying framework (COM-B) and interpretation of the data could be clearer. The authors may like to consider - to really inform implementation learnings - that it would be helpful to link the COM-B findings to the related Behaviour Change Wheel that sits alongside COM-B. This could be done as deductive analysis using the themes derived from the current inductive approach

Thank you for this comment and the useful reference. We cited the COM-B model as a reference to inform our understanding of behaviour change and help seeking in this context, but we agreed to use an inductive approach and then utilise several theories e.g., Cultural determintent helpseeking model, cognitive model of PTSD, to interpret this analysis.

I would also suggest that the example provided in line 365-371 speaks to opportunity (not capability) and line 372-380 speaks to motivation (not capability) - please review. A useful reference may be http://dx.doi.org/10.1136/emermed-2015-205461

Thank you for highlighting query around opportunity v capability factors. This was something we reviewed as a team and we believe that the example discussed speaks to capability factors because patients were experiencing pain/shock/distress and therefore lacked psychological capability to engage with/retain information. Awareness was considered a psychological capability factor in the original COM-B model (Michie et al., 2011). We agree that this might not be clear to reader, so we have added in the text below:

'Participants in this study felt that due to the trauma of sustaining a burn injury, initial psychological capability to engage with, and retain, information about psychological services whilst on the ward is low'.

We agree that beliefs about mental health/psychology speaks to motivational barriers, see below for line in text:

Patient beliefs about mental health and treatment was perceived by participants to influence access to psychological support. It is widely acknowledged there is a stigma related to mental illness and treatment[29], [30], and that this stigma acts as a motivational barrier to professional support[31].

Minor corrections required for:

> include interview questions as Additional File 1

Agreed and amended

> Section 2.6 is part of results, not method

Agreed and amended

> present quotes in italics, with evidence trial after the quote not before (e.g., P4). Consider reducing the number of quotes to improve readability.

Agreed and amended

> line 439 speaks to generalisability (not transferability)

Agreed and amended

> repetition in lines 74-75 and 449-450 can be removed without loosing impact

Agreed and deleted 449-450

Many thanks once again for your comments and taking the time to read our manuscript.