PRIMA EDUCATIONE 2025

AGNIESZKA KAMYK-WAWRYSZUK

Kazimierz Wielki University in Bydgoszcz
https://orcid.org/0000-0002-0545-6416
agnieszka.kamyk.wawryszuk@gmail.com

Parental Role in Shaping Touch Perception in Mechanically Ventilated Children: A Social Learning Perspective*

Rola rodziców w kształtowaniu percepcji dotyku u dzieci wentylowanych mechanicznie: perspektywa społecznego uczenia się

Abstract: Touch is a source of information for a young child. It may evoke positive associations (with love, a parent's care) or negative emotions (being in the hospital, participating in painful medical procedures). It is perceived in a certain way socially, and the child learns this through observation and imitation. This article aims to describe, from the perspective of social learning, the possibilities of learning positive touch in the relationship between a mechanically ventilated child and a parent. There is a lack of articles describing the role of the parent in internalising the touching behaviour of a mechanically ventilated child in light of social learning theory. As role models, parents demonstrate behaviours associated with positive touch in everyday situations, including during care activities performed while the child is lying down (washing the face and body). The possibility of systematically repeating these actions according to a specific pattern means that the child is repeatedly exposed to modelling stimuli. In this case, these include positive touch and verbal support through calming and soothing messages, which will create a lasting image of the behaviour being modelled.

Keywords: parent; mechanically ventilated child; social learning theory

Abstrakt: Dotyk jest źródłem informacji dla małego dziecka. Może on kojarzyć mu się pozytywnie (z miłością, opieką rodzica) lub przywoływać negatywne emocje (pobyt w szpitalu, udział w bolesnych procedurach medycznych). Jest on postrzegany w sposób określony społecznie, a dziecko uczy się go również poprzez obserwację i naśladownictwo.

* The author of the article declares an independent contribution. This work results from scientific activity No. DEC-2023/07/X/HS6/00254 funded by the National Science Centre.

DOI: 10.17951/PE/2025.9.25-36

Celem artykułu jest opisanie możliwości uczenia się dotyku od rodzica przez dziecko wentylowane mechanicznie w domu w świetle teorii społecznego uczenia się. Brakuje artykułów opisujących rolę rodzica w internalizacji zachowań związanych z dotykiem dziecka wentylowanego mechanicznie w świetle teorii społecznego uczenia się. Przykładem naturalnej sytuacji, w której rodzic (model) prezentuje pozytywny dotyk, mogą być czynności pielęgnacyjne, które wykonuje przy dziecku leżącym, takie jak mycie twarzy. Zarówno codzienność tej sytuacji, jak i możliwość ich systematycznego odtwarzania według określonego schematu powodują, że dziecko jest wielokrotnie eksponowane na bodźce modelujące – w tym przypadku pozytywny dotyk, wsparcie werbalne w postaci uspokajających i kojących komunikatów słownych, które wytworzą trwałe wyobrażenie zachowania.

Słowa kluczowe: rodzic; dziecko wentylowane mechanicznie; teoria społecznego uczenia się

INTRODUCTION

Mechanical ventilation is divided into two basic types: 1) non-invasive (using a mask connected to a ventilator) and 2) invasive (requiring a tracheotomy in a child). Ventilator-assisted lung ventilation removes excess carbon dioxide and increases body oxygenation. Either method can be used by both children and adults at home (Borys & Kubicz, 2021). Thus, a child who is ventilated invasively must have a tracheostomy tube inserted. This means that his stay in the home environment is also associated with the new nursing duties his parents will perform with him, as well as a specially prepared room that considers his needs. Touch will play an essential role in this process. As Zagórska points out, touch will be understood from different perspectives in the literature on the subject. First, it significantly impacts the child's physical, neurophysiological, and psychological development. Second, it has a positive effect on cognitive development. It is also important in emotional and social development. Touch will provide the basis for the formation of strong emotional bonds. It will help build a child's sense of security. It will also provide a form of communication. You can express your emotions and feelings (Zagórska, 2013). Raniszewska-Wyrwa, on the other hand, points to research conducted by the Touch Research Institute, which indicated that a parent's physical contact with an infant results in better development. In contrast, contact with an older child allows him or her to reduce anxiety, among other things. The healing power of touch was recognised centuries ago. It often served as the primary form of combating ailments. The researcher emphasises that there is evidence of the use of touch in the art of healing, if only in the writings of the Far East or ancient Greece (Raniszewska-Wyrwa, 2014). Touch is also a source of information.

A MECHANICALLY VENTILATED CHILD AT HOME AND HIS FAMILY

The care of a mechanically ventilated child is divided into two periods. The first involves his stay in the hospital ward, and the second involves his return to the home environment. Staying at home involves numerous changes, affecting not only the child

but also the family members. Care at home for a mechanically ventilated person is round-the-clock and time-consuming. It is often a reason for one parent to give up work and a career (Dębska et al., 2014; Kózka et al., 2011).

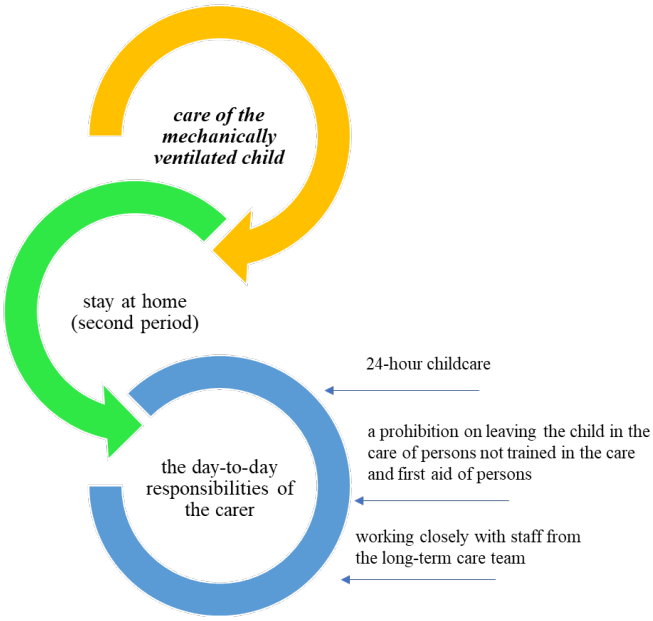

Figure 1. The role of the parent in caring for a mechanically ventilated child at home
Source: Author's own study based on (Stodulska & Biłogan, 2016, pp. 33–40).

A child's stay at home and the associated restrictions can cause him to have limited contact with others outside the family. This means that loved ones spend the most time with the child and are the primary source of contacts, relationships, and experiences. This is often true in the first stage of a child's stay at home, when the family adjusts to the new situation. Over time, teachers, therapists, and other specialists will begin to visit homes, widening the circle of people they reach. Because the child has a chronic disease, family members perform activities with the child that should not be associated with the home, but instead with a hospital ward. As a result, care time is interspersed with medical activities and other tasks appropriate to the child's age and development. The child's stay at home allows the parents to create a friendly, safe, and warm environment where the child will feel loved and valued as a family member. This situation also affects the parent, who experiences a sense of parental fulfilment and satisfaction. He knows that, despite his daughter's/son's illness, he can meet his/son's needs and be in a close relationship with him daily (Kamyk-Wawryszuk, 2023).

BASIC ASSUMPTIONS OF MODELLING AND OBSERVATIONAL LEARNING

According to social learning theory, modelling "leads to learning mainly through its informational function" (Bandura, 2015, p. 38). This means that when exposed to someone else's behaviour, a person creates symbolic representations of the modelled actions, which serve as cues to perform an action or task properly. Given this observational approach, learning will be accomplished using four processes: attention, storage, motor reproduction, and motivational reproduction (Figure 2).

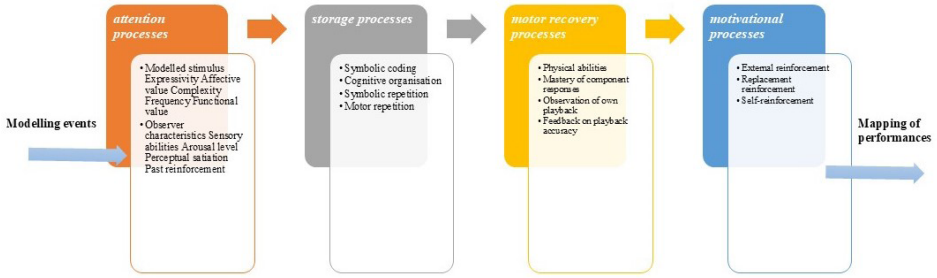

Figure 2. According to social learning theory, component processes play a significant role in observational learning

Source: (Bandura, 2015).

Through observation, a person does not have the opportunity to learn much if they ignore the behaviour being modelled and notice its salient features. Attention processes will determine what a person will selectively observe "amidst the wealth of modelling influences to which he or she is exposed" (Bandura, 2015, p. 38). Additionally, attentional processes determine what a person will extract from such exposure. The scope and types of observational experiences depend on several factors, such as the observer's characteristics or the properties of the modelled activity itself. The multiplicity of the child's observed behaviour is related to who the child can meet. Whether this meeting is due to necessity or choice is irrelevant here. What is important, however, is that he can often observe the behaviours in question and thus "learn them in depth" (Bandura, 2015, p. 38). In a social group, some individuals may be more interesting to others than others. The modelled behaviours will therefore differ in terms of their effectiveness. Bandura stresses that the functional value of the behaviours exhibited by different models will greatly impact which behaviours a person will observe and which ones will be overlooked or rejected. The amount of attention directed at a given model is based on its interpersonal attractiveness. Thus, models that a person finds attractive will attract attention, while those he or she perceives as unattractive are rejected. The rate and level of observational learn-

ing depend partly on the nature of the modelled behaviours. In addition, observers' abilities related to information processing are also relevant here, as they determine how much they will learn from the experience they observe. Bandura also signals that "perceptual attitudes, whether derived from prior experience or related to the demands of the current situation, influence what people extract from observation and how they interpret what they see and hear" (Bandura, 2015, p. 40). Also important in observational learning is remembering or storing the behaviour modelled in memory. The observer can benefit from the model's behaviour, even when the model is absent and directing the behaviour is not possible. In this case, the reaction patterns should be represented symbolically in the observer's memory. Using symbols, momentary modelling experiences will be stored in long-term memory. On the other hand, "advanced symbolisation ability enables people to learn many more behaviours by observation" (Bandura, 2015, p. 40). Observational learning is based on two systems of representation: 1) imaginal and 2) verbal. The first emphasises that people store part of their behaviour in pictorial form. Sensory stimulation will produce impressions in him, giving rise to perceptions of external events. When repeated exposure to modelling stimuli occurs, permanent images of the modelled behaviour will be formed, which people can easily call up from their memory. Imaginations relating to absent physical events can be evoked in later situations. The same is true when the recollection of a repeatedly observed activity triggers the evocation of its imaginary counterpart. In the early stages of a child's development, visual imagination plays an important role in observational learning when they do not use language. The second system of representation, or verbal encoding of modelled events, may be responsible for how a person acquires behaviour by observing and remembering it (Bandura, 2015). The cognitive processes that regulate behaviour are mostly verbal rather than pictorial. When the modelled activity has been converted into imagery and verbal symbols, the information encoded in memory can be useful as behavioural cues. In addition to symbolic encoding, repetition and practice of behaviour are also important for memory. There are behaviours that we learn through observation. However, it is difficult for a person to consolidate them by "playing them overtly, whether because of social prohibitions or lack of opportunity" (Bandura, 2015, p. 41). Imagining oneself performing a behaviour increases both its proficiency and memorability. The highest level of observational learning is achievable when the modelled behaviour is first organised, then repeated symbolically and finally played out openly. The next, or motor reproduction processes, will involve "transforming symbolic representations into appropriate imitative behaviour, including the temporal and spatial organisation of one's behaviour by the model's behaviour" (Bąbel et al., 2014, p. 41), while motivational processes contribute to the fact that a given behaviour will be executed. As Bąbel and his team point out, social learning theory distinguishes between the acquisition of a behaviour and its execution. Not everything a child learns through observation will be subsequently performed. The decision of which behaviour to

perform depends on reinforcement or punishment following the behaviour of the model or observer. If the imitated behaviour is reinforced, there is a greater chance that the observer will perform it. If it is punished, there is less opportunity for the child to perform the modelled behaviour. Although reinforcement is not necessary for observational learning, it impacts whether the behaviour is performed (Bąbel et al., 2014). The researchers emphasise that "from the social learning theory perspective, reinforcement functions not as a consequence of behaviour, as in causal conditioning, but as a factor preceding the observer's behaviour. In this view, the expectation of reinforcement determines whether the model's behaviour is noticed, encoded (as well as repeated), and finally, whether the modelled behaviour is performed (imitation)" (Bąbel et al., 2014, p. 41).

THE PARENT AND THE ROLE IN A MECHANICALLY VENTILATED CHILD'S LEARNING OF TOUCH

The scope of care for a sick child mechanically ventilated at home is considerably greater than that of his or her siblings, and caregivers play a key role in it. The duties they assume in this connection often cannot be performed by others. Because the girl/boy has limited motor skills and relies on the skills the parents have mastered for care, their relationship, regardless of the child's age, is still firmly based on help from an adult. As Migdał and his team point out, the tasks of caregivers in such a situation include, among others: performing nursing tasks with the child, supervising the correctness of mechanical ventilation, systematically observing the child's health and well-being, responding to alarms given by monitoring equipment, caring for the tracheostomy tube, and generally maintaining order and tidiness in the girl/boy's environment (Migdał et al., 2007). According to Płaczkiewicz, in the case of a preschool child, the question can be asked, "How does a young child know how to react in a certain situation or what to say? How to deal with difficulties or obstacles? How to behave towards peers or adults?" (Płaczkiewicz, 2016, p. 134). The researcher points out that a significant way a child acquires behaviour is by observing the ways people react in given situational conditions, serving as models (Płaczkiewicz, 2016). This situation can also be applied to a child who is diagnosed with a chronic disease, is frequently hospitalised due to his condition, and, because of this, may have a limited repertoire of social behaviour. This is due to his previous experience of being hospitalised. The role model will be assumed by the parent, who is always around the child. As mentioned, the attention directed to a given model is due to his interpersonal attractiveness, which is "multifactorial in nature: a set of different elements influences another person's perception as appealing. These can be sorted out by pointing to at least three dimensions. The first – social – is connected with "liking" someone and the affection this person arouses. The next is connected with

task orientation and the anticipation of the benefits of cooperation, or the respect (prestige) that the person inspires, which is considered opinionated and influential. The last is the physical dimension, linked to the individual's appreciable features or clothing (Hołda, 2019, p. 191).

The parent will possess all these qualities. The child loves him, and a relationship based on love, respect, and appreciation appears here. In addition, the caregiver has more knowledge than the child. This is also related to the parents' endowment of trust, which the child manifests when performing various, often painful procedures with him/her. According to social learning theory, the model should have a higher status in the child's perception for a child to imitate specific ways of doing things. This means it should be characterised by specific properties (Bandura, 2015; Płaczkiewicz, 2016). First, for a mechanically ventilated child at home, the caregiver is the person who is physically with him every day. He is also a source of both need satisfaction and need deprivation. He helps to quell pain, satisfy hunger and thirst, and secure the needs for safety and love. It does this in a specific way, creating a particular pattern. The purpose of making the child feel physically and emotionally safe during nursing activities is to relearn adult touch so that it is not associated only with pain and discomfort. It so happens that a child who has experienced pain and suffering resulting from mechanical, impersonal medical procedures knows touch only as something that threatens and causes stress. He may react with screaming, resistance to touch and the same touch, saturated with pain and aggression, may apply to others. According to social learning theory, the aforementioned sensory stimulation triggers a sensation that initiates the perception of external events. Thus, if a child is repeatedly exposed to modelling stimuli – in this case, positive touch and verbal support through reassuring and soothing messages – he will form a lasting image of the behaviour being modelled. This will allow him to recall it quickly and easily in the future. Modelling positive touch can be observed when performing simple grooming activities with a child, such as washing a baby while they are lying down. This natural situation presents a learning opportunity to demonstrate that touch can be a soothing and positive experience. A parent of a sick child uses an algorithm, known as the checklist of nursing actions and procedures, during the washing process. This can be traced through the example of washing the face. The choice of this procedure is based on the fact that if the child has speech therapy or pedagogical therapy classes, the face, neck, and head are the parts of the body that will be subject to the therapists' actions. As Raniszewska-Wyrwa (2014) points out, "touch can be a primary/key tool in therapy or an adjunct to verbal therapy, so in some cases the only or leading therapeutic activity would be direct work with the body (e.g. therapeutic massage), in others – verbal psychotherapy involving touch to varying degrees" (p. 91).

The procedure familiar to the parent shows each step of its execution in detail (Table 1).

Table 1. The procedure for washing the face, eyes and ears

Procedure for washing the face, eyes, and ears in accordance with the nursing algorithm	• helping the patient remove his shirt/pyjama top
	• placing the towel under the patient's head so that its lower corners are at the level of the patient's shoulders
	• lifting the patient's head with the right hand, while sliding the towel with the left hand
	• preparing the flannel intended for washing the face
	• soaking the flannel in water from a bowl without soap
	• wiping the eyes: first the distal eye, then the proximal eye - in the direction from the temples to the nose, and then wiping the eyes thoroughly
	• washing the face in the correct order: in a circular motion, forehead, distal cheek, nasal root, proximal cheek, chin, finally under the nose, mouth (according to the patient's preference, wash with soap and water or water alone),
	• drying the washed face
	• Tilt the ears with slightly moistened gauze pads; gently turn the head and clean the external ear canals of the distal ear, then turn the head in the opposite direction and clean the ear canals
	• of the proximal ear; washing the auricle of the

Source: (Czajkowska et al., 2020, p. 74).

As you can see, the algorithm, step by step, indicates how the caregiver will perform the washing. Below, I present a summary of the procedure for washing the face, based on the checklist of nursing actions, with modifications that parents can make to teach their child positive touch (Figure 3).

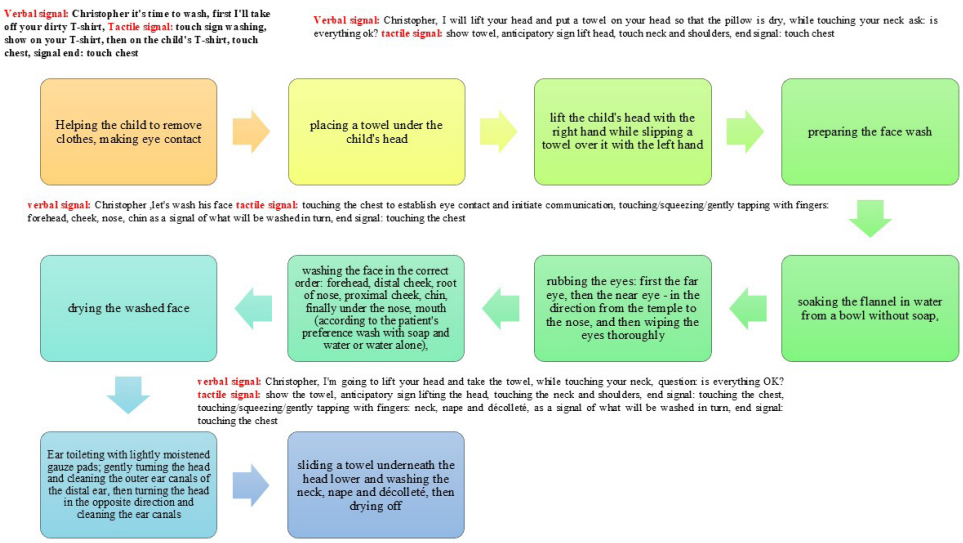

Figure 3. Proposal for modification of the face-washing procedure using elements of social learning theory

Source: Author's own study based on (Czajkowska et al., 2020).

Each activity to be performed is preceded by a verbal and tactile message, so that the child has the opportunity to understand the situation in which he finds himself and to signal discomfort or refuse to perform the activity. This will also give a sense of control and agency over the situation in which he finds himself, which is extremely important in the case of a chronically ill and bedridden child. It also gives him autonomy and a sense that he has a say in what happens to his body. A child who has been hospitalised often associates nursing activities with discomfort. So, introducing anticipatory messages such as "I am going to take off your dirty shirt" or "I am going to pick up your head and put a towel on you" will help the child learn to manage the high level of emotional arousal that can result from the negative experience of medical procedures, which can also hurt the child's health. An adult who enters into an arrangement with a child, according to Konieczna (2019), will, by definition, already show "readiness to include him as a participant in interaction and communicative acts because he formulates fewer demands on him" (p. 55). At the same time, there may be a situation in which he assists the child in his activity, that is, he shows him support both by helping him to formulate an utterance (in the case of a non-speaking, lying child, this will be the formulation of a message by an alternative route, such as using touch) and by creating the conditions that are necessary for him to create an utterance for a given activity (Konieczna, 2019). The cognitive processes that regulate behaviour are most often verbal rather than pictorial. Thus, if the nurturing activity performed by the parent to familiarise the child with positive touch is transformed into both imagery and verbal symbols, the information the girl/boy encodes into memory will become behavioural cues. The constant repetition and practice of this very behaviour will also be significant here (in addition to symbolic encoding).

CONCLUSIONS

According to social learning theory, a child can learn both socially acceptable and socially unacceptable behaviours. Thus, depending on his experience, he may associate touch negatively (due to hospitalisation and the performance of medical procedures) or positively (being hugged by a parent, playing with a sibling) (Kamyk-Wawryszuk, 2025). When it has negative connotations, the need to change this situation arises. This is due, among other things, to what kind of touch a child has learned, which can be applied to others. Showing that touch can be associated with positive connotations will impact his quality of life. It will give a sense of agency and autonomy, and trigger many positive emotions. It will also satisfy the need for security and love (Olearczyk, 2023; Telka, 2020). As mentioned earlier, a child's experience of positive touch can be seen in their cognitive, emotional, and social development. However, the most important aspect from the perspective of the issue addressed in this article is that, according to the researcher, touch provides a basis for forming strong emo-

tional bonds, a sense of security, and creating a positive self-image (Zagórska, 2013). Following Niesporek-Szamburska (2020), it can be said that "touch is also the most universal means of communication – it can move the recipient more deeply than voice and words, and it is interpreted more accurately than facial expressions. Expressed in language, it becomes interesting because it plays an important role in broadly understood contact with the environment" (p. 12).

In the case of a mechanically ventilated child staying at home, this can happen when the parent takes on the role of a model and demonstrates certain tactile behaviours. Thus, when performing activities that cause discomfort, the parent anticipates what will be done with touch and a statement, comforts with touch, hugs, and reassures verbally. By imitating, the child will participate actively in the activity. The child, as an observer, should benefit from the parent's behaviour (model), even when the parent is absent. This means, for example, that it will not react with aggression or resistive behaviour during tasks performed with a special educator or a physiotherapist, who also rely on touch and physical contact within the head and face.

Niesporek-Szamburska (2020) wrote about the relationship between the educator and the child in the context of touch, highlighting that an adult's touch expresses interest and affection, emphasises attention, and responds to a need. The educator's touch, when the child is in the facility, is visible during care activities (wiping the nose, washing hands, etc.), eating, or dressing. These are situations that children with disabilities also experience in the home environment. The researcher emphasises that it can be both supportive, giving a sense of security, and a challenging experience (restrictive, violent, instrumental touch). Therefore, the touch of a parent or caregiver/teacher requires thought, sensitivity, observation, time, and consideration of the child's activity rhythm and physical, cognitive, and emotional predispositions (Niesporek-Szamburska, 2020).

FUTURE RESEARCH

The presented analysis of the possibilities of learning positive touch in the relationship between a ventilated child and a parent from the perspective of social learning theory may serve as a basis for further theoretical analysis and empirical research, including:

- identifying and characterising household activities and everyday activities carried out in the family that will support the application and modelling of positive touch in mechanically ventilated children;
- longitudinal studies on the use of positive touch in the relationship between a mechanically ventilated child and a parent during everyday activities and communicative behaviours related to expressing discomfort during or accepting a given activity, describing the repertoire of behaviours related to touch;

- preparation of guidelines for working with mechanically ventilated children for medical and educational staff, which will take into account the concept of social learning of positive touch and enable a reduction in the level of stress and discomfort in children associated with adult touch.

REFERENCES

Bandura, A. (2015). *Teoria społecznego uczenia się*. PWN.

Bąbel, P., Ostaszewski, P., & Suchowierska, M. (2014). Naśladowanie a uczenie się przez obserwację: porównanie perspektywy analizy zachowania i teorii społecznego uczenia się. *Psychologia Rozwojowa*, *19*(3), 37–47.

Borys, M., & Kubicz, M. (2021). *Raport: wentylacja mechaniczna w Polsce.* JEDNYM TCHEM! Stowarzyszenie pacjentów na rzecz wentylacji domowej. https://ptmr.info.pl/wp-content/uploads/2025/01/Raport-WentylacjaMechaniczna.pdf

Czajkowska, M., Kulik, H., & Augustyniuk, K. (2020). Procedura mycia chorego w łóżku. In K. Augustyniuk & E. Grochans (Eds.), *Check-listy czynności i zabiegów pielęgniarskich. Podstawy pielęgniarstwa* (pp. 72–77). Wyd. Pomorskiego Uniwersytetu Medycznego w Szczecinie.

Dębska, G., Zięba, M., & Krokosz, R. (2014). Domowa wentylacja mechaniczna – specyfika opieki pielęgniarskiej. In H. Kadučáková & M. Magerčiaková (Eds.), *Nové trendy vo vzdelávaní a praxi zdravotníckych pracovníkov* (pp. 21–34). VERBUM – vydavateľstvo KU.

Hołda, R. (2019). Między biologią a kulturą. Atrakcyjność fizyczna w badaniach międzykulturowych. *Relacje Międzykulturowe*, 1(5), 187–207.

Kamyk-Wawryszuk, A. (2023). Sytuacje trudne doświadczane przez rodziców dzieci wentylowanych mechanicznie w domu – wprowadzenie w problematykę. *Niepełnosprawność. Dyskursy Pedagogiki Specjalnej*, *49*, 142–156.

Kamyk-Wawryszuk, A. (2025). Touch as part of parent-child communication with a child mechanically ventilated at home – introduction to the issue. *Specijalna Edukacija i Rehabilitacija*, *24*(3), 311–322. https://doi.org/10.5937/specedreh24-51583

Konieczna, I. (2019). *Komunikacja osoby dorosłej z dzieckiem rozpoczynającym edukację – o wzajemności w rozmowie. Studium teoretyczno-empiryczne z udziałem dzieci ze specjalnymi potrzebami edukacyjnymi*. Wyd. APS.

Kózka, M., Wojtan, S., & Woźniok, E. (2011). Funkcjonowanie psychospołeczne opiekunów chorych wentylowanych mechanicznie w warunkach domowych. *Problemy Pielęgniarstwa*, 19(2), 185–193.

Migdał, M., Jarymowicz, T., Kalbowiak, J. Szreter, T., Świetliński, J., Musialik-Świetlińska, E., Książyk, J., & Łaniewski-Wołłk, P. (2007). Przewlekła wentylacja dzieci w warunkach domowych. *Standardy Medyczne*, *4*, 376–378.

Niesporek-Szamburska, B. (2020). Przed lekturą. Dotyk i jego rola w komunikacji oraz w dziecięcej metaforze synestezyjnej. In B. Niesporek-Szamburska & M. Wójcik-Dudek (Eds.), *Zmysły i literatura dla dzieci i młodzieży* (pp. 11–25). Wyd. UŚ.

Olearczyk, T. (2023). Granice czułości – granice bliskości. Ujęcie interdyscyplinarne. *Edukacja, Biologia i Środowisko*, *1*(79), 90–108. https://doi.org/10.24131/3247.230106

Płaczkiewicz, B. (2016). Teoria społecznego uczenia się a wychowanie dziecka w wieku przedszkolnym. *Społeczeństwo. Edukacja. Język*, *4*, 129–137.

Raniszewska-Wyrwa, A. (2014). Etyka dotyku. Aspekty etyczne wykorzystywania dotyku w praktykach terapeutycznych. *Studia Philosophiae Christianae UKSW*, *50*(2), 85–104.

Stodulska, M., & Biłogan, L. (2016). Wybrane aspekty jakości życia chorych wentylowanych mechanicznie w warunkach domowych oraz ich opiekunów. *Pielęgniarstwo w Anestezjologii i Intensywnej Opiece*, *2*(2), 33–40.

Telka, L. (2020). Dotyk w relacji dziecka i wychowawcy. Przykład żłobka. *Chowanna*, *2*(55), 197–212. https://doi.org/10.5604/01.3001.0014.9859

Zagórska, B. (2013). Znaczenie dotyku we wspomaganiu rozwoju dziecka oraz jego zastosowanie w wybranych rodzajach terapii. *Kultura i Wychowanie*, *5*, 179–192.