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Post-War Research on Post-Traumatic Stress Disorder. Part I. Research before 1989

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Summary

The paper presents the post-war history of post-traumatic research conducted at the Department of Psychiatry of the Jagiellonian University and the analysis of the main research approaches and selected publications. The time after World War II passed in Poland in two directions: coping with the finished war trauma and simultaneously the experience of communist persecution trauma. First scientific publications appeared in the fifties and were focused on the research of former concentration camps prisoners (KZ-Syndrome). Between 1962 and 1989 a special edition of *Przegląd Lekarski*, which concentrated entirely on war trauma research, was published. The journal was nominated for the Peace Nobel Prize twice.

The research team from the Department of Psychiatry headed by Professor Antoni Kepiński made a very extensive description of KZ-Syndrome issues. The paper summarizes the most important contemporary research findings on psychopathology of KZ-Syndrome (Szymusik), reaction dynamics (Teutsch), after camp adjustment (Orwid), paroxysmal hypermnesia (Póltawska), somatic changes (Gatarski, Witusik). The result of the study was the basis for the development of a methodology and a new look at the classification of the consequences of post-traumatic stress disorder, as well as the development of ethical attitudes towards patients.

Key words: PTSD, KZ-Syndrome, *Przegląd Lekarski* – Oświęcim

Introduction

World War II was another source of trauma for Europeans in the twentieth century. World War II differed from World War I in the objectives the warfare attempted to achieve. The aims such as gaining new territories, resources or political domination were no longer of key importance as they were replaced by the desire to exterminate nations. It was the first time in history when military actions were directed against

The study was not sponsored.

civilians on such a large scale. World War I witnessed soldiers fighting with soldiers under the supervision of politicians, whereas during World War II soldiers' military actions, sometimes burdened with a risk of defeat, aimed at civilians' manslaughter. That phenomenon contributed to the occurrence and widespread of trauma and post-traumatic disorders to the extent which had never been experienced before. The group of trauma sufferers was no longer limited to the soldiers coming back from the war front as it was the case after World War I [1] but it included common people and children. This factor shall not be disregarded as it was the main reason for the rise of interest in the post-traumatic disorder medical research in the years following World War II.

World War II brought previously unknown ways of civilians' extermination. During its course numerous concentration camps were erected, particularly, in areas occupied by Germans. The camps served their purpose as the sites of isolation, slave labour and the extermination of individuals who were regarded as the enemies of the German state and nation. People were indefinitely placed there without a court sentence. First Nazi concentration camps were established in Germany in 1933. After the war outbreak they were also set up in Poland. In 1941 the extermination of people in gas chambers was initiated. From 1942 onwards criminal pseudo-medical experiments started to be carried out. Except for extermination camps, work camps were also established. Their living conditions bore much resemblance to the ones in concentration camps. The earliest created types were transit and resettlement camps. Individuals, who were placed there, were further sent for forced labour or resettlement in other parts of Poland, usually in villages where they were forced to do agricultural work for German settlers. The camps, so called *Polenlager*, were destined for the Polish population displaced from the regions of Silesia, Great Poland, Pomerania, Zamość region, Masovia and other provinces. In reality, all camps were created in order to exterminate civilians. All families were placed in camps, especially in transit and resettlement ones. In all of them children were also detained, often separated from their families. Approximately 6,000 Nazi camps were identified in Poland in which 7.5 million persons were imprisoned [2].

Nazi camp prisoners experienced worries about their lives and those of the closest ones before detention or during unjustified detentions e.g. raid or displacement actions not related to their activities. They experienced life-endangering situations during detention, threats of their or their relatives' life loss and transport in life threatening conditions in overcrowded carriages or cars. They were deprived of freedom and forced to slave labour without the possibility of contacting the close ones. Also, they were exposed to hunger, hypothermia and pseudo-medical experiments. The permanent feeling of threat to life was present together with the sense of anonymity and symbolical deprivation of identity.

The second factor that determined the social background of work with persons suffering from post-traumatic disorders was the Nazi persecution of the mentally ill. Approximately 20,000 persons with mental disorders and mental institution personnel are estimated to have been murdered. 7,136 individuals including 574 children are reported to have been successfully identified [3]. The question worth to be posed here is: how does the fact that their patients have been murdered affected the way of thinking and psyche of the psychiatrists (or the entire psychiatric environment)? The first crime

committed on 22nd September 1939 in Kocborowo saw the killing of five members of the hospital staff including the deputy director, dr Józef Kopicz, whose attitude became a symbol of the exemplary rapport between a doctor and patients.

The situation in Poland was additionally marked with further persecutions. It was necessary for individuals to cope with war trauma, a loss of close ones, material losses and interruptions in a private life e.g. education. Simultaneously, the political situation required people to make choices and protect themselves from the persecution of the communist authorities. 300,000 Soviet soldiers accompanied by other persons and personnel are estimated to have stationed in Poland shortly after the war [4]. That certainly posed a threat to the lives of Poles and contributed to the fact that the period of coping with World War II trauma occurred with another traumatic background of political persecution.

So-called KZ-Syndrome

Professor Antoni Kępiński, who is commonly associated with the origins of post-war research of former concentration camp prisoners, in his essay entitled “So-called KZ-Syndrome” recalls the beginnings of the research. It was dr Stanisław Kłodziński who approached him with the initiative to carry out the research, probably in the late fifties. The research, as Kępiński writes, was initiated unwillingly and with resistance as it could potentially interfere with the lives of the saved persons and entail the risk of re-traumatisation [5]. Significantly enough, as early as in 1961 the first issue of the Krakow journal “Przegląd Lekarski” entirely devoted to the presentation of the research results was published. The special edition of “Przegląd Lekarski – Oświęcim” was regularly published until 1991.

Kępiński published ten essays on war trauma himself (those were not typical scientific articles) [5–8]. What seems to be of great interest is the fact that in the majority of them he attempted to characterise the genocide perpetrators’ psyche, which was the subject not present in other publications or research made in Krakow. It only appeared as the theme of the philosophical article of Tadeusz Bilikiewicz, who before the war was associated with the Department of History and Philosophy of Medicine in Krakow [9].

The attempts to identify biological factors responsible for the origin of post-traumatic symptoms were juxtaposed with the attention drawn to the mental trauma occurring with great strength and exceeding the usual experience of a human being. However, the stimuli were so inconceivable for the persons lacking the experience of concentration camp imprisonment that they constituted the source of misunderstandings [7]. Similarly, the symptoms of consequences contributed to the lack of understanding in “outside” observers and researchers. Except for hypermnesia, a classical example was the so-called survivor syndrome which was defined as a paradoxical guilt stemming from survival despite the one time death of other persons. The syndrome was particularly prevalent in persons who were sent to concentration camps because of their Jewish origin [10]. A significant percentage of individuals who suffered from trauma resulting from the stay in a concentration camp was distinctive not only because of

the characteristics of the disorder but also because of the peculiarities of difficulties in adjustment to life after the time spent in a concentration camp.

Between 1961 and 1991 the total of 31 volumes of the special edition of "Przegląd Lekarski" was issued. The issues included as many as 1,050 articles contributed by 477 authors (including 65 professors). To mark this achievement, the journal was twice nominated for the Peace Nobel Prize in the nineties [11].

The attempts to summarise such a vast scope of the research and its findings in a concise paper may not be feasible, especially while considering the fact that numerous publications were of a great volume. Such papers as the descriptions of the concentration camp language or dream research comprise of dozens of pages with their volume and scope being equivalent to doctoral theses. Notwithstanding, we will attempt to outline a few selected notions below.

The notion of KZ-Syndrome by Szymusik

Considering the specificity of the group, the most common terms were: progressive asthenia, post concentration camp disease, post concentration camp asthenia, chronic progressive post concentration camp asthenia, KZ-syndrome, post concentration camp syndrome, concentration camp syndrome [12]. The terminology directed meticulous attention to the circumstances of the disorder origin: the isolation in a concentration camp. It was suggested that the psychopathological image may be dependent on an individual characteristic of the trauma [5]. These views were in line with those previously proposed by Jaspers [13]. Targowla [14] introduced the term "asthenia progressiva gravis" which departed from the particular distinction of a trauma type as the cause of a disorder and focussed principally on clinical symptoms instead [15]. The major symptoms included: pre-mature aging, weight loss and blood vascular disorders, depression with a mild cyclic course, adjustment difficulties, dysthymia, lowered self-esteem, symptoms of autonomic nervous system dystonia and sleep disorders. Their cause was traced in the impaired functioning of the pituitary-adrenal axis leading to progressive body exhaustion. The process was reported to occur in 3 stages: fatigability followed by the tendency to concentrate on own ailments and experienced trauma and the fits of remembering the experienced trauma [16]. The research was conducted by professor Adam Szymusik, the future Head of the Department Psychiatry of Jagiellonian University Medical College, whose publications investigated primarily the characterisation of the former concentration camp prisoners' health conditions.

In case of classification, it was noted that disorders such as reactive psychosis and reactive hysteria were virtually non-existent in the examined group [15]. At that time episodic reactive conditions, which were virtually an acute reaction to stress, and reactive psychoses together with reactive hysteria were distinguished in reactive disorders. The long-lasting dispute over reactive psychoses took place. It attempted to find the answer to the question if reactive psychoses constitute a response to a stimulus or whether they are endogenic psychoses activated as a result of trauma [13]. Reactive depression was long regarded as the most likely reaction. However, the condition was disregarded in the modern classifications in contrast to brief (acute) reactive psychosis

which combined elements of reactive hypomanic-disphoric syndrome, reactive paranoid syndrome, delusional syndromes and syndromes similar to schizophrenia. Reactive hysteria syndromes (with elements of psychotic syndromes) such as: Ganser syndrome, pseudo-dementia or puerilism practically ceased to be diagnosed and they stayed in classifications, for instance, as dissociative disorders unspecified [17].

Reaction dynamics by Teutsch

Dr Aleksander Teutsch investigated the characteristics of an acute reaction to stress as we would define it at present, which in other words can be understood as the descriptions of a reaction when an individual finds oneself in a concentration camp and the reaction dynamics [18]. The first trauma involved the very fact of being in a concentration camp and the related range of the concentration camp experiences. A prisoner had only several weeks to adjust or otherwise he or she would die. It was crucial to limit one's sensitivity to external stimuli but not to such a great extent that would restrict completely a person's functioning and lead to the state of "muslimisation" which, in the concentration camp language, meant the state of numbness, and most probably of dissociation. The second element put forward by Teutsch was a psychophysical unity understood as the interdependence of mental and physical reactions resulting in death or severe course of disorders in persons who were resigned and prostrate due to the exhaustion of body adjustment capabilities. The last factor – camp autism – was defined as the capability of being closed in one's own experience and detached from any exchange with the external world, which would restrict the exposure to traumatic stimuli. It differed from pathological autism in a way that it demonstrated the limited capability of staying in touch with others and receiving and offering support [19]. Those factors constituted the picture of KZ-syndrome making it distinctive from the nature and course of other similar post-traumatic syndromes.

Post concentration camp adjustment by Orwid

Professor Maria Orwid, who was the founder and for many years the head of the Children and Youth Psychiatry Clinic, researched the distant reaction to trauma. In her work she distinguished three groups of disorders: (1) associated with severely impaired social functioning the picture of complaints about physical weakness, fatigability, apathy and unwillingness to initiate contact with others and (2) the type defined as hypercompensation resulting in a role fulfilment disorder and manifesting itself through excessive social activity. The third group (3) was characterised by the capability of social functioning with the occurrence of numerous complaints about subjective difficulties in adjustment to social conventions and applicable norms. Orwid emphasised that the disorders were present for many years after the traumatic factor receded [20]. In a detailed statistical analysis no significant differences in life adjustment difficulties after releasing from the camp were observed if such variables as gender, age, financial and social status while being free were considered. The only differences occurred in the category of education level as a higher prevalence of disorders occurred among

intelligentsia. Also, in the category of the length of imprisonment a proportional dependence was observed. A significant majority demonstrated better life adjustment in the camp than while being free. Except for the above mentioned reaction types, the former prisoners shared the difficulties in entering and maintaining interpersonal contacts, especially with persons who did not experience the trauma. They were characterised by the reluctance to start new relationships and maintaining even those friendships which started before the concentration camp experience. Additionally, they tended to be socially isolated and maintained contacts only with other former prisoners. Those tendencies were accompanied by the strong feeling of distinctiveness and loneliness even in the company of the closest persons. Simultaneously, the feeling of otherness from other people was observed. That was complemented with the situations in which the trauma was attributed with immense importance, which in exceptional cases was manifested with the attitude of having extraordinary expectations from others and was usually associated with a strong feeling of injustice [21]. Dr Roman Leśniak concluded in his doctoral thesis that no correlation between a personality type and the way of reaction to concentration camp conditions and post camp adjustment was observed [22].

Paroxysmal hypermnesia by Póltawska

The symptoms of recurrent memories typical of post-traumatic disorders were thoroughly presented by dr Wanda Póltawska who coined the term of paroxysmal hypermnesia. As she wrote, the fits may recur themselves or as a result of stimuli reminiscent of the trauma. They may be characterised by the tendency to accumulate unpleasant memories in the form of images, not thoughts. The images that fully reconstruct sensual impressions and are frequently accompanied by the feeling of realistic reliving of the scene. A person experiencing a paroxysm of hypermnesia is often aware of the compelling nature of the phenomenon and a lack of control over it [23]. Those states were reported as typical of progressive asthenia. They were less prevalent in depressive conditions in which the tendency to paroxysm was much less apparent and the memories had stable (more conscious) disposition to revisit the traumatic past while reliving experiences. Furthermore, the tendency to a higher frequency and strength of hypermnesia paroxysms was observed with a more advanced age of the patients despite the occurrence of memory disorders [24].

Somatic changes

The research scope of the former concentration camp prisoners' health condition involved numerous diverse clinical issues.

The examinations with the use of the then available and specialised diagnostic methods were carried out. In electroencephalography scan (EEG) a considerable percentage of abnormal EEG reading oscillating between 41% and 53% of the former prisoners was observed. Also, the concurrence of psychoorganic syndrome symptoms developed as a result of imprisonment and pathological EEG reading was noted [25]. The percentage was proven to be on the increase in persons who spent time in a camp

during childhood [26]. Psychiatric examinations were extended to somatic condition and laboratory tests. A higher frequency of systemic and infectious somatic diseases in the former prisoners was observed. Additionally, circulation disorders, rheumatic diseases, disorders of the gastrointestinal tract and others occurred at a higher frequency with tuberculosis being the most common infectious diseases [27].

The results of the experiment carried out on animals were presented. The animal diet, which was designed in accordance with the feeding scheme in a camp, after 3 months causes a typical syndrome of starvation sickness even if no quantity limits are imposed [28]. Numerous states of undernourishment resulted in the occurrence of irreversible body changes i.a. in a central nervous system leading even to an eventual death [29]. In other cases they could result in irreversible changes which would not remit after the application of a pharmacological treatment with vitamin formulations.

Summary of KZ-Syndrome research

The outcome of the conducted research was not only limited to the presentation of epidemiology and specificity of post-traumatic disorders in persons imprisoned in concentration camps. It also offered the methodology bases and a fresh view on the classification of post-traumatic stress consequences [30]. The methods adopted while collecting and processing the research material as well as the fact of building up contact must have combined empathy with scientific distance [6].

Notwithstanding the extensive KZ-syndrome research, the notion was not well established in the Polish psychiatry and its depiction was limited to a “chronic occurrence of diverse illnesses in the same person” [31].

The chapter shall not be completed without the emphasis on the significance of the research achievements in scientific ethical legal and other fields. The research outcomes offered the foundations for establishing the guidelines in pension cases of the former prisoners. They also had an impact on the formulation of ethical attitudes with some researchers devoting their whole life to the investigations of the subject.

However, no publication that would sum up the research has been published. It would have been clear that the outcome is not solely a simple summary of results from single examinations but if taken with a more holistic approach, they characterise in a perfect and undoubtedly extensive manner the picture of a reaction to trauma. Having analysed the investigated notions, we receive the complete picture of the present post-traumatic stress disorder – PTSD, F 43.1 according to ICD-10.

Table 1. **Comparative analysis of study results on the KZ-Syndrome and the current knowledge of PTSD**

	Post Traumatic Stress Disorder (PTSD) Year 1980 and later	KZ-Syndrome 1950s and later – 20 th century
Trauma	A1 Criterion – initially a Specific Trauma, since 1987 an Unspecified Trauma A2 Criterion – Emotional Reaction	Specific Trauma Reaction Dynamics (Teutsch)

table continued on the next page

I	Group B Symptoms – Re-experiencing	Hypernesia (Półtawska)
II	Group C Symptoms – Social Withdrawal	Avoidance Hypercompensation Adjustment (Orwid)
III	Group D Symptoms – Arousal	Arousal (Szymusik)
IV	Others Increase of Symptoms with Age A Lack of Personality Predisposition Accompanying Somatic Disorders Depressive Symptoms – DSM-5, 2014	Others Increase of Symptoms with Age (Gałarski) A Lack of Personality Predisposition (Leśniak) Accompanying Somatic Disorders (Witusik) Depressive Reaction (Orwid, Szymusik)

Półtawska presented the symptoms of recurrent memories as a reaction to symbolic stimuli or those associated with trauma. Orwid described the symptoms of avoidance and disorders in social functioning, whereas Szymusik focused on the symptoms of constant agitation. Teutsch, on the other hand, offered the characteristics of symptoms of what is currently known as an acute reaction to stress – ASD F43.0 according to ICD-10.

Furthermore, various specific notions, which became of research interest many years later, were reported. Leśniak observed that no personality predisposition for a reaction to trauma exists, whereas Gałarski pointed out to the significance of young age while experiencing trauma on the development of later psychopathology. Both Gałarski and Orwid focused on the strengthening of symptoms with age as a consequence of decreasing compensatory capabilities. Unfortunately, the publications only indirectly suggested that they constitute part of the research on “the post concentration camp syndrome” understood as a reaction to a specific trauma.

It is worth emphasising that it was only in the amended edition of DSM-III-R of 1987 when the post-traumatic stress disorder was reported as a syndrome irrespective of the trauma type as the previous edition of DSM-III of 1980 included the notion of war trauma. Some other symptoms e.g. a depressive reaction and not only anxiety one, already reported by the KZ-syndrome researchers in the sixties, were introduced into DSM as late as in 2013 (DSM-5) [32].

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