

# Gluteus Minimus

Each issue highlights a specific muscle or group of muscles, and presents techniques to restore muscles from a compromised state to optimal health.



By Victoria Ross  
& Chuck Selvaggio

**T**he gluteus minimus muscle has a significant relationship to structural balance within the body. Although the textbooks describe the gluteus minimus as a hip/thigh abductor, they also describe its more significant role as a pelvic stabilizer. The following discussion pertains to gluteus minimus' role in structural problems.

Thérèse Pfrimmer wrote at length about adherent factors within muscles. Adherencies are tissues that are stuck or attached to each other (but not to the degree as found in scar tissue). Practitioners of myofascial release are aware that a restricted or adherent muscle can compromise the alignment of the joints of the body in the standing posture, the resting posture or during movement. The gluteus minimus is no exception.

## Structural factors

Gluteus minimus and gluteus medius together make up a significant part of the picture when considering the structural alignment of the body in the standing posture, and even more of the picture when considering the structural alignment of the body during movement.

In the standing posture, the compensation that occurs due to the shortened gluteus minimus/medius is a pelvic tilt, low on the side of the shortness. In the walking posture, the role of the gluteus minimus/medius is particularly unique, as the most important function of these muscles is to keep the pelvis balanced while the foot on the opposite side is taken off the ground.

During walking, when one foot is taken off the ground, the gluteus minimus and medius together, on the opposite side, keep the pelvis stable, suspended in space, until

the foot hits the ground again. In practical terms, since the client might do a lot of walking and/or shifting around in a chair, the deeply hidden gluteus minimus can be kept quite busy as a pelvic stabilizer during an average day. When it is in a healthy state, it quietly supports the structural balance of the body in many positions and movements. Conversely, when it is adherent, it restricts the free flow of movement—not only in the gait but also during many other common daily movements.

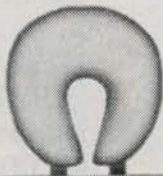
Again considering the influence of the gluteus minimus on standing posture, numerous minute chain reactions can occur when the gluteus minimus/medius is shortened and the balance of the pelvis is compromised. Gluteus minimus can participate in a series of chain reactions occurring along the body in the standing posture, both superiorly and inferiorly to the pelvis. A few examples of pain that may be hidden in this chain reaction are back pain, neck tension, shoulder girdle distress, headaches, hip or knee complaints, and ankle and arch imbalances.

Another factor to consider in this picture of structural imbalance is the influence of the gluteus minimus/medius on the very common problem known as apparent leg-length discrepancy. In this case, the leg bones are not actually shortened, but various factors—including contracted muscles

on the “short leg” side of the body—may make it appear that way. The gluteus minimus and medius attach at the anterior border of the greater trochanter of the femur, so when they shorten the position of the leg is altered. The femur may be pulled upward (superiorly) and/or medially rotated. This gives the appearance of a shorter leg when the client's heels are placed together in the prone position.

Any deviation in the normal tone of the gluteus minimus/medius, whether in the direction of hypotonicity or hypertonicity, may be reflected as a change in the apparent leg length. It has been clinically observed that isolating and releasing adherencies in the gluteus minimus muscle will often allow the apparent leg-length discrepancy to resolve. This simple and safe approach is helpful with chronic leg-length discrepancies and the chain reactions that can occur in the body when leg length is compromised.

Muscles that present on the lateral aspect of the body (such as the scalenes, the obliques and the gluteus medius/minimus) can play a significant role in bilateral postural/structural problems. This can be looked at like a simple mechanical problem: If the sides of the building are weak, the whole structure is compromised. In the human body, the compromised structure is determined to remain upright, so bilateral



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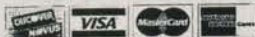
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compensation occurs. A client may present with a right hip-left shoulder-right neck syndrome as a reflection of bilateral compensation. Logically, and again mechanically, the supportive structures that are most inferior in the body are likely to be more fundamental to the problem.

For instance, a lumbar problem is often caused by weak arches, and a neck problem is often caused by an L-5/S-1 compromise. The weight-bearing hip sockets transfer the body's weight from the legs to the trunk and the whole upper body. But, because the hip is a versatile ball-and-socket joint, there is much potential for instability at this focal weight-bearing point. (Little wonder that hip socket replacements are fairly common in older clients and that chiropractors' offices are filled with patients with chronic apparent leg-length discrepancies.)

Looking one more time at the frequency of apparent leg-length discrepancies, it is helpful to visualize the mechanical marvel of the head, neck and greater trochanter of the femur. The average person tends to visualize their legs as two sticks going straight into the trunk at a ball joint somewhere on the lower end of the trunk. But the angle of the femur is a marvel of mechanics. The line of weight-bearing ascends from the knee, first laterally then medially, as it angles in through the neck of the femur, and into the ball-and-socket joint at the acetabulum.

This unique design allows for great versatility and flexibility of the legs.

However, the many muscle fibers converging on the attachment surfaces (from such muscles as the psoas, gluteus maximus, medius and minimus, piriformis, obturators, gemellus and quadratus femoris) open up real potential for the femoral neck and femur to be pulled out of its ideal position. Once this happens, leg "length" is thrown off and the structural chain reactions begin. Leg-length discrepancies represent a Pandora's box filled with ammunition for undermining the body's structural balance.

### Solutions

Releasing adherency in the gluteus minimus is simple to perform once the therapist identifies (through palpation) what the gluteus minimus in a distressed state feels like. What may be confusing to the student is that most textbooks describe the minimus as not palpable. However, when it is distressed, it becomes palpable and can be sensed right along the line where the side-seam of trousers usually falls. When palpating along the seam area, you can sense a cord running along this same vertical line, deep in the hip (between the greater trochanter and the iliac crest). As with other muscles, tissues and organs in the body, palpation becomes more difficult when the tissues are healthy than when they are distressed.

## Pfrimmer Explained

Pfrimmer Deep Muscle Therapy is the total-body corrective muscle therapy system developed by Thérèse C. Pfrimmer, of Ontario, Canada, in the 1940s (for a detailed description of the therapy, see "Pfrimmer Deep Muscle Therapy," Issue #74, July/Aug. 1998). Her comprehensive and highly refined technique of specific cross-fiber strokes works effectively to restore muscles and prevent various muscle/soft-tissue conditions.

The study and application of Pfrimmer Deep Muscle Therapy consists of two important corrective phases: 1) The total-body sequence of general corrective strokes; and 2) The localized spot work of specific corrective strokes called Pfrimmer Muscle Isolation.

For further information about Pfrimmer Deep Muscle Therapy, contact the Pfrimmer Institute at P.O. Box 150918, San Rafael, CA 94915-0918, (888) 355-2698, or visit its web site at [www.piforcmt.com](http://www.piforcmt.com)

# How to Apply Pfrimmer Muscle Isolation to Gluteus Minimus

1. Position the client in the side-lying position.
2. Stand behind the client.
3. Support the client's body so that it does not roll (you can place a pillow between yourself and the client).
4. With your eight fingers in a row, compress them on the cord line of the gluteus minimus.
5. Work anteriorly across the fibers with a slow, deep movement; then return across the fibers without snapping or twanging the muscle.
6. Place your thumbs backward and sink them deeply and slowly into the cord line.
7. Roll slowly back and forth across the fibers.
8. Push the whole cord back and forth to clear the underbelly.
9. Reposition the client into the prone position. Compress the gluteus minimus with your thumb (to clear the underbelly and release fascial restrictions around the joint), while rotating the lower leg slowly in both directions with your free hand.



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For example, a lymph gland in the neck is very easy to find when it is swollen, but “disappears” when it is healthy; or a client suddenly finds a bone sticking out in their neck, when it is merely a scalene that “disappears” once it is relaxed. Like the psoas, because of its depth, the gluteus minimus is challenging for the therapist to locate the first time, but once discovered it becomes quite easy.

During the administration of the basic Pfrimmer sequence, attention is given to the gluteus minimus through the compression of the medius muscle to the depths of the underlying minimus. This work may be too superficial, however, to help a restricted (or distressed) minimus—in which case the therapist must change her position, as well as that of the client, in order to isolate the muscle and work through the restriction (see “How to Apply Pfrimmer Muscle Isolation to Gluteus Minimus,” page 148).

The gluteus minimus may be released with the client in the supine position, the prone position or the side-lying position. The side-lying position is usually preferred by the therapist when isolating the gluteus minimus. It is also very effective for the therapist to compress the gluteus minimus with her thumb while reaching with the free hand to rotate (circumduct) the lower leg slowly in both directions (with the client in

the prone position). This will gently release the underbelly of the muscle and balance the connective tissues supporting the angle of the femoral neck.

Other muscle groups with attachments on either the femur or the pelvic bones must be evaluated and released of adherent factors in order to make a hip correction complete. Also, the potential chain-reaction areas, both superior and inferior to the hip, noted above, must also be comprehensively addressed (remember, a total-body treatment approach is invaluable when addressing structural problems, as the assurance of comprehensive coverage is increased both for the therapist and for the client). *M*

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**Please note**

The material presented in this article is not a substitute for hands-on training. Readers should self-assess to make sure they have sufficient education and experience to understand the information presented here and to safely perform the described technique.

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