Benefits and safety of squatting during labor

Why squatting is considered a physiologic labor position

Squatting places the body in an upright, flexed-hip position. Compared with lying flat on the back, it changes the relationship between the uterus, pelvis, pelvic floor, and maternal trunk. In late labor, this can help the sacrum and coccyx move more freely, allow the pelvic outlet to open, and align the fetus with the birth canal. The effect is not magical or guaranteed, but it is biomechanically plausible and supported by clinical observation.

Many labor units now encourage upright positions during labor when it is safe to do so. Squatting is one of these upright options, along with standing, kneeling, leaning forward, sitting on a birth ball, and using hands-and-knees. These positions may reduce prolonged pressure on the vena cava and aorta compared with flat supine positioning, which can matter for maternal blood return and uteroplacental perfusion.

Squatting is most commonly used during the second stage, when the cervix is fully dilated and the birthing person feels an urge to push. However, some people briefly squat during active labor contractions because it relieves back pressure or helps the pelvis feel more open. It does not need to be held continuously. In fact, alternating squatting with rest positions often makes it

more tolerable.

Potential benefits for pushing and the second stage

The main proposed benefit of squatting is improved efficiency during descent and birth. When the torso is upright, gravity may assist the presenting part in applying pressure to the pelvic floor. Hip flexion and abduction can also increase the functional space available at the pelvic outlet. For some people, this creates a stronger, clearer urge to bear down.

A hospital-based randomized controlled trial comparing normal delivery in a squatting position versus a lying-down position found several clinically relevant differences in uncomplicated deliveries. The squatting group had a significantly shorter second stage of labor, reduced need for oxytocin administration, and less extension of episiotomy compared with the lying-down group. Maternal satisfaction related to pain severity was also higher among those who squatted.

These findings do not mean squatting is always superior for every birth. Labor outcomes depend on fetal position, parity, pelvic floor tone, analgesia, fatigue, clinician support, and many other variables. Still, the evidence supports squatting as a reasonable option in selected low-risk situations, especially when the birthing person feels stable and the fetal heart rate tracing remains reassuring.

Some people also report that squatting makes pushing feel more coordinated. It may pair well with open-glottis pushing, in which the person exhales or vocalizes while bearing down rather than holding the breath for prolonged counts. This may reduce unnecessary tension and help pushing feel more body-led.

Pain, control, and emotional experience

Pain in labor is not only a sensory event; it is also shaped by fear, position, muscle tension, fatigue, and the feeling of being able to participate in decisions. Squatting can offer a sense of agency because the person is actively using the body rather than remaining confined to one position. For some, this improves coping and reduces the perception of helplessness.

Squatting may be particularly helpful when pressure is felt low in the pelvis or when back labor improves with forward-leaning positions. It can be combined with sacral counterpressure, warm compresses, water immersion if permitted, rhythmic breathing, or verbal coaching. Supported squatting in labor also allows a partner, doula, midwife, or nurse to provide physical and emotional reassurance.

However, squatting can also intensify pelvic pressure. Some people find that the position makes contractions feel stronger or the urge to push overwhelming. That is not a failure. It may simply mean the body needs a different position, such as side-lying, kneeling over the raised head of the bed, or semi-sitting. The best labor position is often the one that supports progress while preserving safety, endurance, and emotional steadiness.

Maternal satisfaction is an important outcome. A position that helps someone feel respected, informed, and physically supported can positively influence the memory of birth, even when labor is challenging. Squatting should therefore be offered as an option, not imposed as a performance standard.

Safety considerations and when squatting may not fit

Squatting during childbirth is generally considered safe for many uncomplicated labors when the birthing person has adequate strength, balance, and clinical support. Safety is individualized. The care team may recommend avoiding or modifying squatting if there is nonreassuring fetal heart rate status, significant bleeding, severe hypertension symptoms, maternal dizziness, mobility limitations, dense epidural motor block, or a need for immediate operative access.

Continuous fetal heart rate assessment may still be possible in upright positions, but the monitor may need adjustment. Wireless telemetry can make movement easier, while standard external monitors sometimes shift during deep flexion. If fetal monitoring becomes unreliable, the team may ask for a position change to obtain a clear tracing.

Squatting can also be physically demanding. Late pregnancy and labor alter balance, joint laxity, and muscle endurance. A deep unsupported squat may increase the chance of slipping, knee discomfort, ankle strain, or sudden

fatigue. People with pelvic girdle pain, prior hip or knee injury, significant symphysis pubis dysfunction, or certain neurologic or musculoskeletal conditions should discuss modifications in advance.

An epidural does not automatically rule out squatting, but it changes the safety equation. If leg strength and sensation are reduced, unsupported squatting is usually unsafe. Some units may offer assisted squatting with a squat bar, lowered bed, or two-person support, while others may recommend side-lying or semi-upright alternatives. The priority is preventing falls and maintaining rapid access if birth needs to be assisted.

How to squat safely during labor

Safe squatting is usually supported, brief, and adaptable. It does not require holding a deep squat for long periods. Many people use the position for one or several contractions, then rest between contractions on the bed, a stool, a birth ball, or in side-lying. This rhythm helps conserve energy.

Use stable support. A squat bar attached to the labor bed, a partner's forearms, a rebozo, wall bars, or a birthing stool can reduce strain and improve balance.
Keep the feet grounded. A wide stance with the heels supported is often more stable than balancing on the toes.
Let the pelvis move. Small rocking motions, leaning forward, or changing foot angle may help comfort and descent.
Rest between contractions. Squatting continuously can fatigue the legs and pelvic floor.
Respond to feedback. If dizziness, sharp joint pain, excessive bleeding, or fetal heart rate concerns occur, change position and follow clinical guidance.

Preparation can help. Prenatal squats, when cleared by a healthcare professional, may improve lower-body strength, hip mobility, and pelvic floor awareness in uncomplicated pregnancies. Fitness guidance commonly emphasizes bodyweight squats, limited range of motion if needed, support from a chair or wall, and avoidance of heavy or high-intensity squatting late in pregnancy unless specifically cleared and well supervised.

Squatting practice is not meant to force the body into birth readiness. It is

simply a way to learn alignment, breathing, and support strategies before labor begins.

Discussing squatting with your birth team

If squatting appeals to you, bring it up during prenatal visits rather than waiting until active labor. Ask whether your planned birth setting has squat bars, birthing stools, floor mats, wireless monitoring, or staff familiar with upright pushing. This conversation is especially useful if you are planning epidural analgesia, induction, vaginal birth after cesarean, or a low-intervention birth plan.

You might ask: In what situations would squatting be encouraged? When would you recommend changing positions? Can fetal monitoring be performed while upright? Is the bed adjustable for supported squatting? How do you protect the perineum in a squat? What alternatives are available if I am too tired or numb to squat?

Perineal outcomes deserve a nuanced discussion. Squatting may reduce the need for episiotomy in some settings, yet it can also create rapid descent in certain births. Controlled pushing, communication with the clinician, warm compresses, and slowing the birth of the head when appropriate may all help manage perineal stretch. No position can eliminate the possibility of perineal tears after vaginal birth.

The most supportive plan is flexible. You may intend to squat and then prefer side-lying. You may assume you will stay in bed and then discover that upright movement feels best. Labor often changes quickly, and good care honors both physiologic birth and medical responsiveness. Squatting is safest when it remains one tool among many, guided by your body, your preferences, and real-time clinical assessment.