Best pushing techniques explained

What pushing technique actually means

In labor, pushing technique refers to the way a person coordinates breath, abdominal effort, and pelvic floor relaxation to help the fetus descend through the pelvis. Clinicians often discuss this within the second stage of labor, which begins at full cervical dilation and ends with birth. In practice, technique is less about maximal force and more about timing force with a contraction and directing pressure along the birth canal.

The commonly described approaches include spontaneous pushing, directed pushing, open-glottis pushing, and closed-glottis or Valsalva pushing. Spontaneous pushing means following the body’s own urge to bear down. Directed pushing adds coaching from the birth team. Open-glottis pushing usually involves exhaling or gently vocalizing while bearing down. Closed-glottis pushing involves taking a deep breath and holding it while pushing hard for a set interval.

These are not rigid categories in real life. Many people shift among them as labor progresses, fatigue changes, or analgesia alters sensation. The practical question is not which method sounds ideal in theory, but which method supports steady descent, preserves maternal stamina, and matches the baby’s condition.

Open-glottis and closed-glottis pushing

Open-glottis pushing is often favored in modern labor coaching because it keeps the airway open and lets the person exhale during effort. That can reduce the sensation of strain and may help avoid prolonged breath-holding. Many people find it easier to recover between contractions when they do not fully brace for the entire push.

Closed-glottis pushing, often called Valsalva pushing, uses a deep inhalation followed by breath-holding and strong abdominal contraction. This method can generate high intra-abdominal pressure quickly, which is one reason it has historically been used in coached settings. However, that pressure does not automatically translate to better outcomes, and sustained breath-holding can be tiring. It may also feel less natural for some people, especially later in labor or when they are using an epidural and need clearer coaching for rhythm.

The evidence reviews do not show a consistent clinical winner for routine use. The more defensible approach is to treat open-glottis pushing during birth as a useful default when the patient can coordinate it well, while recognizing that closed-glottis pushing may still be used selectively depending on local practice and clinical circumstances.

Spontaneous, directed, and delayed pushing

Spontaneous pushing means bearing down when the urge is strongest rather than on a fixed command. For some people, this is the most efficient pattern because it aligns with the body’s own reflexes. It can be especially helpful when the fetus is low and the person feels a strong rectal or pelvic pressure that rises with contractions.

Directed pushing adds explicit instructions from the clinician or doula, such as when to start, how long to hold, and when to rest. This can be useful when the person is uncertain how to channel the contraction, when there is an epidural and sensation is blunted, or when the care team wants to coordinate with fetal monitoring. The downside is that too much coaching can create tension, shorten recovery time, or encourage pushing before the body is ready.

Delayed pushing, sometimes called laboring down, is a short pause after full dilation before active pushing begins. It may allow the fetus to descend further on its own, which can reduce the duration of active pushing in some settings. The evidence is mixed, so it is best viewed as a selective strategy rather than a universal rule. The phrase laboring down before pushing is useful because it captures the idea: sometimes the most efficient next step is to wait briefly and let contractions do some of the work.

Breathing, pelvic floor relaxation, and body mechanics

Breathing is not a side issue. It is central to how pressure is transmitted through the diaphragm and abdominal wall. A person who is tense through the jaw, neck, or pelvic floor often spends more energy resisting the contraction than directing it. That is why clinicians often emphasize pelvic floor relaxation during birth alongside active pushing.

In open-glottis pushing, the person exhales into the contraction rather than locking the breath. That can help keep the pelvic floor softer and allow incremental descent. In closed-glottis pushing, the abdominal wall generates greater pressure, but the tradeoff is less flexibility and often more fatigue. Many labor teams use a blended approach: bear down hard enough to be effective, but release the jaw, shoulders, and perineum between pushes.

Position matters too. Upright, kneeling, side-lying, hands-and-knees, or squatting positions can all change how gravity and pelvic diameters interact with fetal descent. No single posture is best for everyone. The useful question is which position lets the pelvis open, the hips stay mobile, and the pushing effort stay coordinated with the contraction. Good mechanics usually look calm rather than dramatic.

How clinicians choose the right technique in the moment

Evidence reviews of the second stage of labor generally do not support one routine pushing method for all births. That means clinical judgment matters. The team may change course based on fetal heart rate patterns, maternal exhaustion, epidural level, parity, malposition, or whether progress has slowed. A person who is pushing effectively with spontaneous effort may need very little direction. Another person may need short, specific cues to avoid

wasting energy.

Coached pushing during contractions is often used when the birth team needs tighter coordination, but coaching should remain responsive rather than rigid. If the person is red-faced, holding the breath too long, or unable to recover, that usually signals the need for a less forceful pattern. If the baby is descending well and the person feels in control, more directive instruction may add little.

In practical terms, the best technique is the one that produces steady descent without unnecessary strain. That may mean open-glottis pushing, a brief period of delayed pushing with epidural, or a return to spontaneous pushing once sensation improves. The goal is adaptation, not performance.

Practical cues that support effective pushing

A few simple cues are often more useful than complicated instructions. Start with a full contraction, then take the breath that feels most natural. Direct the effort downward and forward, not upward into the face or neck. Keep the shoulders soft, the jaw loose, and the hands relaxed if possible. Between contractions, recover fully so the next push does not begin from a state of tension.

It also helps to think in terms of intervals. A strong push is usually short and purposeful, followed by a deliberate reset. If there is no urge to bear down, forcing effort may not help. If there is a strong urge, delaying too long can create frustration. In many births, a rhythm emerges that looks almost athletic: prepare, bear down, release, and rest.

Because the evidence does not show one universal method, the most useful advice is to stay responsive. If pushing feels efficient, continue. If it feels misdirected, change posture, breathe differently, or ask the team to reassess. That is not a failure of technique; it is normal labor management.