

Breathing techniques for pushing



Why breathing changes during the pushing stage

The pushing stage, or second stage of labor, begins when the cervix is fully dilated and the baby moves down through the pelvis. At this point, contractions often feel different: instead of a rising wave of pain alone, many people feel rectal pressure, pelvic fullness, and an involuntary urge to bear down. Breathing techniques for pushing work best when they respect this physiology rather than trying to override it.

During a contraction, the uterus generates force from above while the abdominal wall, diaphragm, and pelvic floor coordinate around that force. The diaphragm descends with inhalation and rises with exhalation; the pelvic floor also responds to pressure and relaxation. If the jaw, throat, and pelvic floor tighten together, descent may feel more effortful. If the throat stays open and the exhale is steady, some people find it easier to direct effort downward without rigid bracing.

Breathing also gives the brain a task. In a highly intense moment, a simple rhythm can reduce panic, support oxygenation, and help you hear your team. That does not mean breathing can remove the work of birth. It means it can create organization in a phase that may otherwise feel chaotic.

Open-glottis pushing: exhaling with effort

Open-glottis pushing means bearing down while air is moving out through an open throat. The glottis is the space between the vocal cords. When it remains open, you may exhale with a sigh, hum, moan, groan, or low vocal sound while pushing. This is sometimes called physiologic pushing, spontaneous pushing, or breathing the baby down, although those terms are not identical in every clinical setting.

A common pattern is to inhale as the contraction builds, then exhale while gently or strongly bearing down for the length of the urge. Instead of one long breath hold, you may use several shorter pushes during the contraction, each paired with an exhale. Some educators suggest practicing a 4-to-6-count inhale followed by a 4-to-6-count exhale, then adapting the rhythm once labor sensations become more powerful.

The practical cue is simple: keep the throat open. You might imagine fogging a mirror, sighing out through a relaxed mouth, or making a low "ah," "oh," or "grrr" sound. Low vocalization is not about being quiet or loud; it is about avoiding a tight, high, throat-clenched effort. Lamaze International describes open-glottis techniques and vocalization as strategies that may reduce unnecessary pelvic floor tension and may be associated with less pelvic floor trauma in some research contexts.

Open-glottis pushing can be especially helpful for people who feel a strong spontaneous urge to push. It may also be useful when the birth team is encouraging gradual descent rather than rapid, maximal effort. However, it is not a rule. If fetal heart rate concerns, maternal exhaustion, operative birth planning, or other clinical factors arise, your team may recommend a different approach.

Closed-glottis pushing and when it may be used

Closed-glottis pushing is the classic "take a deep breath, hold it, and push" technique. In this method, the glottis closes, the breath is held, and intra-abdominal pressure increases. It is sometimes called Valsalva-style pushing. In many hospitals, it has been used with coached counting, often for about 10 seconds at a time.

This technique can create strong expulsive force, and some clinicians may use it selectively when a more directed push is needed. For example, it may be suggested when a person has dense regional anesthesia and cannot feel the urge to push clearly, when pushing efforts are not moving the baby effectively, or when the team is trying to shorten the second stage for a specific medical reason. Even then, many educators recommend avoiding unnecessarily prolonged breath holds. Shorter breath holds, such as around 6 to 8 seconds, may be easier to recover from than repeated long holds.

The concern with prolonged closed-glottis pushing is that it can increase maternal fatigue, reduce the chance to breathe regularly, and intensify downward pressure on pelvic tissues. Some guidance also cautions against routine breath-holding while pushing. North Bristol NHS Trust, for example, advises not holding the breath while pushing and emphasizes gentle blowing or panting when the baby is being born.

If your care team uses coached pushing, you can still ask for individualized guidance: "Can I exhale while I push?" or "Can we use shorter pushes?" These questions are reasonable, especially if you feel lightheaded, overwhelmed, or unable to recover between contractions.

Breathing between contractions: recovery matters

The moments between pushing contractions are not empty time; they are recovery time. After a push, the uterus relaxes, blood flow patterns shift, and you may have a brief chance to restore oxygenation, soften muscles, and prepare for the next wave. Many people instinctively drop the head back, close the eyes, and breathe deeply. This is useful.

A simple recovery pattern is to release the shoulders, unclench the jaw, and take one or two slow breaths in through the nose or mouth and out through a relaxed mouth. If you are trembling, nauseated, or emotionally flooded, a longer exhale may help settle the sympathetic nervous system. Your support person can quietly cue, "Release your jaw," "Breathe out slowly," or "Rest your legs."

For medically literate readers, it may help to think in terms of pressure

management. Pushing increases intra-abdominal pressure; recovery breathing reduces global bracing and allows the pelvic floor and perineal tissues to accommodate stretch. The aim is not limpness, because birth requires effort, but coordinated effort followed by true release.

If fetal monitoring is in use, the team may also use the pause to assess fetal heart rate recovery. If they ask you to change position, pause pushing, or breathe rather than bear down, they are responding to real-time clinical information. Your preferred rhythm is important, but it should remain flexible.

Crowning: panting, blowing, and slowing the head

Crowning is the phase when the widest part of the baby's head stretches the vaginal opening and perineum. Sensations may include burning, stinging, pressure, or a powerful urge to push hard. This is often the exact moment when the birth team asks for less force, not more. The reason is mechanical: a slower, controlled emergence may allow perineal tissues more time to stretch.

Gentle blowing, panting, or "sigh out slowly" breathing can help reduce the intensity of bearing down. North Bristol NHS Trust describes an SOS approach, meaning "Sigh Out Slowly," and suggests blowing just hard enough to flicker a candle flame. Other practical cues include "blow out candles," "pant with your tongue out," or "little breaths." The point is not the exact phrase; it is to prevent an explosive final push if your clinician is guiding a controlled birth of the head.

During crowning, your midwife or obstetrician may provide perineal support during birth, apply warm compresses, or guide the speed of delivery with verbal cues. You may hear instructions such as "small breaths," "stop pushing," or "just breathe." These can be difficult to follow because the reflex to push may be extremely strong. Practicing in advance can make the cue more familiar, but no one should feel guilty if the body takes over.

A useful rehearsal is to inhale gently, then make two or three light pants followed by a slow blow. Keep the jaw loose and tongue relaxed. If you notice your face tightening, try opening the mouth wider; many people find that an open mouth helps the pelvic floor soften.

Vocalization, the jaw, and the pelvic floor

Low vocal sounds can be more than emotional expression; they can be a physiologic tool. The throat, diaphragm, abdominal wall, and pelvic floor are connected through pressure systems and neuromuscular patterns. When the jaw clenches and the throat closes, many people also tighten the pelvic floor and buttocks. When the mouth opens and the sound drops lower, the body may reduce guarding.

Useful sounds include humming, moaning, growling, or a low "ooo" or "aaa." Some childbirth educators specifically teach growling or "grrr" sounds during effort because they keep air moving while allowing intensity. The sound does not need to be pretty. It should feel functional, grounded, and sustainable.

If you feel self-conscious, remember that birth teams are accustomed to vocal labor. Sound is information: it may show that you are moving with the contraction, coping, and keeping the glottis open. A support person can help by lowering their own voice and breathing slowly near you rather than talking rapidly or repeatedly telling you to relax.

There are situations where vocalizing may not be your preference or may not feel possible, especially with exhaustion, nausea, epidural-related numbness, or emotional overload. In that case, focus on the same principle in a quieter way: exhale through parted lips, soften the jaw, and avoid locking the throat for longer than your team recommends.

Adapting breathing to epidural anesthesia and coached pushing

With an epidural, the urge to push may be reduced, delayed, or changed. Some people still feel strong pressure; others feel only tightening or no clear urge at all. Breathing during pushing may therefore become more coached. Your nurse, midwife, or obstetrician may use contraction monitoring, palpation, or your reported sensations to time pushing efforts.

Even with an epidural, open-glottis pushing may be possible. You can inhale as the contraction begins, curl around the baby if advised, and exhale while bearing down. If you cannot feel whether the effort is effective, your team may offer feedback. Sometimes they may suggest a closed-glottis push for more

force, but you can ask whether shorter breath holds or exhale-pushing are appropriate.

Position also changes breathing mechanics. Side-lying may allow the pelvic floor to soften and can be useful when slowing crowning. Hands-and-knees may help some people manage back pressure. Semi-recumbent positions can be necessary for monitoring or assisted birth but may require more conscious effort to avoid neck and jaw bracing. Whatever the position, the breath should support the strategy rather than compete with it.

If forceps, vacuum assistance, shoulder dystocia maneuvers, significant fetal heart rate abnormalities, or postpartum hemorrhage concerns arise, follow the immediate instructions of the clinical team. In those moments, safety takes priority over any planned breathing technique.

How to practice before labor

Practice should be brief, gentle, and not involve repeated forceful bearing down during pregnancy unless your clinician or pelvic health physiotherapist specifically instructs you. The aim is familiarity with breath patterns, not training yourself to strain.

You can rehearse open-glottis coordination by sitting upright, inhaling comfortably, then exhaling with a low sound while imagining the pelvic floor widening. Another option is to place one hand on the lower ribs and one on the lower abdomen, noticing how the rib cage expands with inhalation and softens with exhalation. For crowning practice, try gentle candle-blowing breaths or light panting for a few seconds, then return to normal breathing.

Choose two simple cues, such as "open throat" and "slow blow," rather than memorizing many patterns.

Ask your birth partner to practice saying cues calmly and briefly.

Discuss preferences for open-glottis pushing in your birth plan, while noting that clinical circumstances may change.

If you have pelvic floor pain, prior severe tearing, respiratory disease, cardiac disease, or a high-risk pregnancy, ask for individualized guidance.

Good preparation also includes learning about the pushing stage and delivery,

because breathing is only one part of the second stage. Positioning, fetal descent, contraction strength, perineal support, maternal energy, and clinical decision-making all shape how pushing unfolds.